

October 2005

**“We Shall Travel On”:
Quality of Care, Economic Development,
and the International Migration of
Long-Term Care Workers**

by

**Donald L. Redfoot
Ari N. Houser**

AARP Public Policy Institute

The Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group of AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of interest to older Americans. This paper represents part of that effort.

The views expressed herein are for information, debate, and discussion and do not necessarily represent formal policies of AARP.

Copyright © 2005
Reprinting with permission only
AARP, 601 E Street NW
Washington, DC 20049

ACKNOWLEDGMENTS

The authors gratefully acknowledge the contributions of the many people who have helped with this report. First of all, we thank the AARP Public Policy Institute staff who reviewed this report in various stages of development: Wendy Fox-Grage, Mary Jo Gibson, Enid Kassner, Keith Lind, Sheel Pandya, Sara Rix, and Bernadette Wright. Rhonda Richards from AARP Federal Affairs and Charlotte Nusberg in AARP's Research Information Center also reviewed the report and provided helpful comments. We are also grateful for comments and suggestions from external reviewers: Andreas Hoff of Oxford University; Walter Leutz of Brandeis University; Debra Lipson of Mathematica Policy Research; and Pascal Zurn of the Organization for Economic Co-operation and Development. Finally, we appreciate AARP's International Affairs Director, Ladan Manteghi, for initiating this project, and Jessica Frank and Bradley Schurman on the International Affairs staff for their suggestions and assistance.

TABLE OF CONTENTS

| | |
|--|------------|
| Table of Tables | vii |
| Table of Figures..... | vi |
| Foreword..... | vii |
| Executive Summary | ix |
| I. Introduction—Long-Term Care Workforce: A Crisis in the Making? | 1 |
| II. Purposes..... | 2 |
| III. Methodology | 3 |
| IV. Demographic, Economic, and Social Factors Shaping International Labor Markets and the Migration of Long-Term Care Workers | 4 |
| A. Demographic Trends..... | 4 |
| B. Skill Levels and Working Conditions | 7 |
| C. Gender and Race | 9 |
| D. Historical and Geographic Relations | 11 |
| V. Policy Decisions and the International Migration of Long-Term Care Workers | 13 |
| A. Long-Term Care Financing Policies..... | 13 |
| B. Immigration Policies | 14 |
| C. Education and Credentialing | 15 |
| D. Worker Recruitment..... | 19 |
| VI. Snapshots of Migration and Long-Term Care Workers in More Developed Countries..... | 20 |
| A. Japan | 21 |
| B. Scandinavian Countries..... | 22 |
| C. Italy | 23 |
| D. Austria..... | 25 |

| | |
|---|-----------|
| E. United Kingdom | 26 |
| VII. The Migration of Long-Term Care Workers and Countries of Origin: Brain Drain or Pathway to Development? | 27 |
| A. Skill Levels—Brain Drain or Transfer of Skills? | 28 |
| B. Economic Impact—Route to Development or Loss of Investment? | 32 |
| C. Education—Raising or Lowering Standards? | 34 |
| D. Gender—Liberation for Women or a New Dual Labor Market? | 35 |
| E. Integrating Foreign Long-Term Care Workers—Professional Enhancement or Discrimination? | 36 |
| VIII. How Is the Quality of Long-Term Care Affected by the Use of International Workers? | 37 |
| A. Is Immigration the Best Way to Address Worker Shortages? | 37 |
| B. How Can Public Agencies Be Sure that International Workers Are Qualified? | 38 |
| C. How Can Developed Countries Meet the Demand for Unskilled Workers? | 39 |
| D. How Do Cultural and Linguistic Differences Affect Quality of Care? | 40 |
| E. Do Migrants Depress Wages and Undermine Working Conditions? | 41 |
| F. What Responsibility Do Developed Countries Have for the Impact on Source Countries? | 42 |
| IX. Conclusions | 43 |
| References | 46 |
| Appendix A—Analysis of Census Data and Comparability between Years | 59 |
| Appendix B—Detailed Data on International Long-Term Workers in the United States | 63 |

TABLE OF TABLES

| | |
|---|----|
| Table 1: Projected Changes in Population Characteristics in Select Developed Countries between 2005 and 2050 | 5 |
| Table 2: Old Age and Total Dependency Ratios in Select Developed Countries | 6 |
| Table 3: The Number and Percentage of Foreign-Born Nurses and Nurse Aides in Long-Term Care Settings in the United States from the Top Five Countries of Origin, 2000 | 13 |
| Table 4: Time and Cost Required to Complete Steps for U.S. RN Licensure..... | 17 |
| Table 5: Average Months and Cost Required to Complete Steps for U.S. RN Licensure | 17 |
| Table 6: Skill Levels of Expatriates from Select Source Countries..... | 31 |
| Table 7: Monthly Wages of Nurses from Source Countries and Host Countries in U.S. Dollars, Purchase Parity Pay Estimates (Most Recent Data from Each Country)..... | 32 |
| Table 8: Percentage of Foreign Nurse Graduates Who Felt They Received the Same Level of Respect as or More Respect than U.S.-Born Nurses | 36 |

APPENDIX A TABLES

| | |
|---|----|
| Table A1: Definitions of Occupation and Setting (Industry) Categories Used in This Report, 1980–90 (1990 codes) and 2000–03 (2000 codes) | 59 |
| Table A2: Comparability of Nurses—1990 Census Data—Numbers of Workers by 1990 Occupation Categories and Redistributed into 2000 Occupation Categories | 60 |
| Table A3: Comparability of Aides—1990 Census Data—Numbers of Workers by 1990 Occupation Categories and Redistributed into 2000 Occupation Categories | 61 |
| Table A4: Comparability of Hospital Settings—1990 Census Data—Numbers of Workers by 1990 Industry Categories and Redistributed into 2000 Industry Categories | 61 |
| Table A5: Comparability of Long-Term Care Settings—1990 Census Data—Numbers of Workers by 1990 Industry Categories and Redistributed into 2000 Industry Categories | 61 |
| Table A6: Comparability of Other Health Care Settings—1990 Census Data—Numbers of Workers by 1990 Industry Categories and Redistributed into 2000 Industry Categories | 62 |

APPENDIX B TABLES

| | |
|--|----|
| Table B1: Rate and Number of Immigrants to the United States, by Period..... | 64 |
| Table B2: Foreign-Born Population, Total and Percentage of U.S. Population | 64 |
| Table B3: Foreign-Born Nurses and Nurse Aides in LTC Settings, 1980–2003..... | 65 |
| Table B4: Regions of Origin—Foreign-Born Nurses in LTC Settings, 1980–2000 | 65 |
| Table B5: Regions of Origin—Foreign-Born Nurse Aides in LTC Settings, 1980–2000..... | 65 |
| Table B6: Percentage of Foreign-Born Nurses in LTC Settings from Various Regions and Countries, by Length of Residence in the United States, 2000..... | 66 |
| Table B7: Percentage of Foreign-Born Nurse Aides in LTC Settings from Various Regions and Countries, by Length of Residence in the United States, 2000..... | 66 |
| Table B8: Gender of Nurses and Nurse Aides by Nativity, 2000..... | 67 |
| Table B9: Age of Nurses and Nurse Aides in LTC Settings, by Nativity, 2000 | 67 |
| Table B10: Average Age of Registered and Practical Nurses Who Passed Their Exams between September 1 and November 30, 2002 | 67 |
| Table B11: Race/Ethnicity of Nurses in LTC Settings, 1980–2000 | 68 |
| Table B12: Race/Ethnicity of Nurse Aides in LTC Settings, 1980–2000 | 68 |
| Table B13: Numbers and Percentages of First-Time, Internationally Trained RN Candidates for U.S. Licensure Examination from Selected Countries, 1999–2003 | 68 |
| Table B14: Select Characteristics of Foreign-Born Nurses and Nurse Aides in LTC Compared with Other Health Care Settings in the United States, 2000 | 69 |
| Table B15: Percentage and Number of Health Care Workers Who Worked in LTC Settings, by Length of Residence in the United States, 1980–2003 | 69 |
| Table B16: Percentage of Nurses and Nurses Aides in LTC Settings Who Were Foreign Born, by Region, 1980–2000 | 70 |
| Table B17: Top Five States in Number of Foreign-Born Nurse Aides in LTC Settings and Percentage of Foreign-Born Nurse Aides in These States, 1980–2000 | 70 |
| Table B18: Top Five States in Number of Foreign-Born Nurses in LTC Settings and Percentage of Foreign-Born Nurses Who Were in These States, 1980–2000 | 70 |
| Table B19: Nurses in LTC Settings, by Metro Location, 1980–2000 | 71 |

| | |
|---|----|
| Table B20: Nurse Aides in LTC Settings, by Metro Location, 1980–2000 | 71 |
| Table B21: Percentage of Nurses and Nurse Aides in LTC Settings Who are Foreign-Born, by Metro Status, 1980–2000 | 72 |
| Table B22: Primary Reasons for Coming to the United States | 72 |
| Table B23: Initial U.S. Visa Categories of Foreign Nurse Graduates | 73 |
| Table B24: Years of Education, Nurses and Nurse Aides, 2000 | 73 |
| Table B25: Basic Education for Registered Nurses by Country of Origin..... | 74 |
| Table B26: English Proficiency, Nurses and Aides in LTC Settings, 2000 | 74 |
| Table B27: Interviewer Rating of English Skills of Graduates of Foreign Nursing Schools, Who Are Candidates for RN License..... | 75 |
| Table B28: Communication Issues among Foreign- and U.S.-Trained Registered and Practical Nurses | 75 |
| Table B29: Years of Work Experience among Foreign Nurse Graduates before Coming to the United States | 76 |
| Table B30: Involvement in Errors Reported by Newly Licensed Nurses | 76 |
| Table B31: Income, Nurses and Nurse Aides in LTC Settings, 2000 | 77 |
| Table B32: Poverty Status among Nurses and Nurse Aides in LTC Settings, by Nativity, 2000 | 77 |

TABLE OF FIGURES

| | |
|---|----|
| Figure 1: Internationally Educated Newly Licensed Registered Nurses, US and UK, 2000-2004 | 8 |
| Figure 2: Race/Ethnicity of Foreign- and Native-Born Nurses in Long-Term Care Settings, 1980-2000 | 10 |
| Figure 3: Race/Ethnicity of Foreign- and Native-Born Nurse Aides in Long-Term Care Settings, 1980-2000 | 13 |
| Figure 4: Initial Overseas Admissions to the UK Nurses and Midwifery Council Registry by County, 1998-2004..... | 17 |
| Figure 5: Years of Education, Nurse Aides in Long-Term Care Settings in the U.S., by Place of Birth, 2000 | 17 |
| Figure 6: Percentage of Foreign-born Aides and Nurses in Long-Term Care Settings, by Region of Origin, 2000 | 31 |
| Figure 7: Percentage of World Remittances to Select Developing Countries, 2000 | 32 |

FOREWORD

International trade and outsourcing jobs in various industries, such as manufacturing and communications, receive regular attention in the press, in political discussions, and in policy meetings. Illegal immigration is also the focus of much attention. In contrast, much less is known or discussed concerning the increasing internationalization of the workforce in health and long-term care. Interest in these areas usually focuses on professional workers, particularly doctors and nurses.

With little public awareness, an increasing number of workers in the paraprofessional long-term care workforce of developed nations are immigrants from less developed nations. Still less noted are the large number of unskilled workers, who often work in a gray economy with extra-legal immigration and payment arrangements. These workers are key to meeting the increasing need for assistance in many developed nations as they cope with rapidly aging populations and declining numbers of native-born workers.

The International Affairs office at AARP asked the AARP Public Policy Institute to examine the myriad issues related to the international migration of long-term care workers—professional, paraprofessional, and unskilled. Institute staff members Don Redfoot and Ari Houser have assembled diverse research and data sources to examine how this international migration affects those who emigrate and the countries they leave behind, as well as the quality of the assistance they provide to persons with disabilities in their new countries.

The Public Policy Institute offers the report in the hope that policy decision makers, practitioners, and consumers will better understand the complex economic and cultural issues surrounding the migration of long-term care workers that will require policy decisions in our increasingly interdependent world.

Elizabeth Clemmer
Associate Director
AARP Public Policy Institute

EXECUTIVE SUMMARY

I. Introduction—Long-Term Care Workforce: A Crisis in the Making?

The theme of the Filipino Nurses' Hymn, "We shall travel on," was meant to inspire newly trained nurses to travel to remote locations to bring health care services to underserved regions of the country (Choy, 2003). But the phrase has taken on new meaning as increasing numbers of nurses have left the Philippines, with their government's encouragement, for employment in the United States, the Middle East, and the European Union. In recent years, 70 percent of nurse graduates in the Philippines have "traveled on" to other countries, joining an army of more than 15,000 nurses who leave the country each year (Bach, 2003). Similar scenes are playing out in India, China, sub-Saharan Africa, the Caribbean, Eastern Europe, and the Pacific Islands as tens of thousands of nurses, aides, and domestic caregivers leave their homelands each year to work in more developed countries. The overwhelming majority of these workers are women, and many end up providing long-term care services to the aging populations in developed countries.

This report examines demographic, social, and political factors driving the increased international migration of workers to provide long-term care services in developed countries. These factors affect the availability and quality of long-term care services in the developed countries, as well as the availability of health care services and the economic development of the developing countries that are the source of these workers. The report raises policy questions with which individual countries, as well as international organizations concerned with the needs of both developed and developing countries in our complex and changing world, must deal.

But the international migration of long-term care workers is not just a national or international issue. Some of the most compelling issues are played out in the lives of individuals who make the difficult decision to leave their homelands, their families, and their ways of life to seek opportunity in a new land—and the individuals with disabilities whose lives they touch and support. International agreements and national policies that do not deal with the aspirations and needs of both the persons with disabilities and their caregivers are doomed to failure.

II. Purposes

The purposes of the report are to:

1. outline factors that shape international labor markets for long-term care workers, including demography, skill levels, gender and race, and historical and geographic relationships;
2. describe how policy decisions regarding long-term care financing, immigration, credentialing, and recruitment affect long-term care labor markets;
3. provide brief snapshots of how international labor markets affect the provision of long-term care in select developed countries;

4. report patterns of migration among health and long-term care workers from developing countries and the effects of this migration on the provision of health care and economic development in those countries;
5. summarize how the growing use of international workers affects the quality of long-term care services and outline policy decisions that may affect quality; and
6. examine in depth the use of foreign-born workers in long-term care settings in the United States, included in Appendix B.

III. Methodology

While a complete picture of the international migration patterns of long-term care workers is not possible, this report uses three methods to piece together what we can learn from existing data and what gaps still exist in our knowledge.

- The first is a review of the disparate literature on migration patterns, the demography of developed and developing countries, and international comparisons of long-term care systems and immigration policies.
- The second method involves analyzing data compiled by international and national organizations, such as the United Nations Population Division, the Organization for Economic Co-operation and Development (OECD), the National Council of State Boards of Nursing, and the Council of Graduates of Foreign Nursing Schools.
- The third method employed original analyses of trends in the employment of foreign-born nurses and nurse aides in long-term care settings in the United States, using U.S. Census and American Community Survey data.

IV. Demographic, Economic, and Social Factors Shaping International Labor Markets and the Migration of Long-Term Care Workers

Part IV examines the demographic, economic, and social factors shaping international labor markets for long-term care workers in developed countries, including:

- *Demographic Trends*—The demographic challenge to developed countries is twofold: 1) an aging population requiring more long-term care services, and 2) a diminishing supply of workers to fill the jobs associated with long-term care. In the two oldest nations, Italy and Japan, the number of people age 80 and older is projected to more than triple, from 5 percent to nearly 17 percent by 2050; however, the number of working age people (age 15–64) is projected to decline by 38 percent during that period.
- *Skill Levels and Working Conditions*—As part of more general trends affecting health and long-term care, the demand for workers is at both higher skill levels (e.g., skilled nurses) and lower skill levels (e.g., nursing home aides and home care assistants). In 2004, the United Kingdom (UK) and the United States each licensed more than 15,000 new internationally trained registered nurses. These nurses represented 44

percent of the new nurses in the UK and 15 percent of new nurses in the United States.

- *Gender and Race*—Migrating women from racial minority groups provide increasing amounts of long-term care in several developed countries. The proportion of foreign-born nurses in U.S. long-term care settings who are white declined from 45 percent in 1980 to 18 percent in 2000; during the same period, the proportion of black nurses increased from 16 percent to 30 percent, and that of Asian nurses increased from 29 percent to 38 percent.
- *Historical and Geographic Relations*—Migration often follows historical patterns of former colonies to colonial powers (e.g., the Philippines to the United States) or geographic proximity (e.g., Hungary to Austria). Between 1998/99 and 2003/2004, the proportion of foreign-trained new registered nurses who came from developed countries in the European Union (EU), Australia, New Zealand, the United States, and Canada declined from 72 percent to 19 percent—with the offsetting increases coming from the Philippines and former British colonies in Asia and Africa.

V. Policy Decisions and the International Migration of Long-Term Care Workers

Policy decisions also play a major role, intentional and unintentional, in the volume and patterns of international migration to provide long-term care. Part V evaluates the impact of policy decisions in the following areas:

- *Long-Term Care Financing Policies*—Public policies on long-term care financing reflect and reinforce service delivery models and traditions of family responsibility, which affect the demand for various types of international workers. The proportion of older people in institutions ranges from 2.2 percent in Italy to 7.9 percent in Sweden.
- *Immigration Policies*—Even in the face of demographic challenges, most developed countries have been reluctant to open their doors to more immigration, especially to unskilled workers. Japan has some of the most restrictive immigration policies with the result that only 110 foreign “medical service” workers (doctors and nurses) worked in the country in 2003.
- *Education and Credentialing*—Nations establish education and credentialing requirements to help assure quality of care; these requirements can also be used as a method for limiting the admission of long-term care workers, especially nurses. Of 19,903 nurses who began the process of applying for the U.S. prescreening exam in 2003, only 3,482 received visa screen certificates; slightly more than half of these nurses could expect to pass the licensing exam on the first attempt.
- *Worker Recruitment*—Selective recruitment, formal and informal, also shapes the migration patterns of long-term care workers, especially among skilled nurses. Despite a code of ethics restricting the recruitment of nurses from certain countries, one of every four overseas nurses who were qualified in the UK in 2002–2003 were from countries on the Department of Health’s proscribed list.

VI. Snapshots of Migration and Long-Term Care Workers in More Developed Countries

Part VI explores how the factors shaping international long-term care labor markets are experienced in specific developed countries receiving the workers. These countries were chosen because they represent different approaches to long-term care financing and immigration, which have resulted in different patterns of worker migration.

- *Japan*—Japan has some of the most pressing demographic needs but still has very restrictive immigration policies. In a recent survey, 83 percent of Japanese respondents opposed increased immigration by foreign workers.
- *Scandinavian Countries*—Sweden and Norway fund a substantial array of home-based and institutional services, mostly provided by public agencies, with small but growing numbers of foreign-born workers employed in long-term care. The OECD reports that 19.3 percent of the foreign workers in Norway and 20.3 percent of those in Sweden work in the “health and other community services” sector, the highest percentages reported among OECD countries.
- *Italy*—The combination of a strong tradition of care by families and friends, changing roles of women, and a modest cash benefit financing system has fueled a huge demand for home care workers in Italy to augment family caregiving. Roughly half a million low-skill and mostly undocumented international workers provide supportive services to older people in their homes.
- *Austria*—One of every eight people in Austria (12.5 percent) is foreign born, slightly higher than the 12.3 percent in the United States, which is generally thought to be more open to immigration. Substantial cash benefits, little regulatory oversight, and a tradition of home care have encouraged substantial use of international long-term care workers in Austria, many of whom are illegal but are openly recruited by agencies for short-term, rotating care duty.
- *United Kingdom*—The UK is one of the largest importers of professional health care workers in the world, a large percentage of whom work in the long-term care system. The number of newly registered nurses from Africa quadrupled between 1998/99 and 2003/2004.
- *United States*—The number and percentage of foreign-born workers in U.S. long-term care settings have increased substantially, especially in central cities where more than one of four nurses and aides is foreign born. Overall, the proportion of foreign-born workers in long-term care settings rose from 6 percent in 1980 to 16 percent in 2003.

VII. The Migration of Long-Term Care Workers and Countries of Origin: Brain Drain or Pathway to Development?

Part VII examines factors driving international long-term care labor markets from the perspective of the source countries. Often, the economic and professional incentives to migrate from the perspective of individual workers may create problems for the health care systems of their home countries. Short-term effects can also be quite different from long-term effects. The complex issues related to migration from the perspective of less developed countries include:

- *Skill Levels—Brain Drain or Transfer of Skills?* Whether the movement of health care professionals is a “drain,” a “strain,” or a “gain” depends on at least three factors: 1) the number of health care workers a source country has compared to its health needs; 2) the percentage of the skilled workforce that migrates; and 3) the patterns of migration from and return to less developed countries. Many sub-Saharan African countries have fewer than 20 nurses per 100,000 population, compared to more than 1,000 in Norway and Finland.
- *Economic Impact—Route to Development or Loss of Investment?* The net effects of immigration on economic development are not uniform or entirely clear. Remittances are an important source of revenue to developing countries, but they also come at the expense of the loss of workers who are better educated and at the peak of their productive years. Estimates of income from remittances, much of which comes from health care workers, are roughly the same as estimates of total gross domestic product (GDP) in Samoa and Tonga.
- *Education—Raising or Lowering Standards?* Migration has had both positive and negative consequences for the quality of nurse education. Some nurses are taught to international standards so that graduating nursing students can pass licensing exams in other countries. But in some countries, such as the Philippines and India, the quality of the new nursing schools created to meet increased demand is uneven.
- *Gender—Liberation for Women or a New Dual Labor Market?* In 2000, women represented 51 percent of migrants in more developed countries, but only 45 percent of migrants in less developed countries. Nursing continues to provide professional opportunities and personal liberation to women from less developed countries, but exploitation is distressingly common as well.
- *Integrating Foreign Long-Term Care Workers—Professional Enhancement or Discrimination?* Integrating migrating nurses and aides can be a major challenge for employers and workers. Discrimination based on race or foreign-born status from clients, fellow professionals, and administrators is reported frequently.

VIII. How Is the Quality of Long-Term Care Affected by the Use of International Workers?

The degree to which international workers improve the quality of services or create problems is a very complicated question—involving multiple policy objectives and definitions of “quality.” Part VIII outlines the limited evidence regarding quality and international workers and raises policy issues that must be addressed.

- *Is Immigration the Best Way to Address Worker Shortages?* To the extent that international workers relieve the stresses of staffing shortages, they can be one part of a strategy to improve the quality of care, but many countries will have to deal with tough questions related to increased immigration.
- *How Can Public Agencies Be Sure that International Workers Are Qualified?* International workers compare reasonably well on many measures of quality, but assuring that the migrating workers are able to do the work is a continuing concern.
- *How Can Developed Countries Meet the Demand for Unskilled Workers?* Most long-term care work is done by unlicensed, low-skill workers. Quality measures are likely to focus increasingly on care from unskilled, often illegal workers.
- *How Do Cultural and Linguistic Differences Affect Quality of Care?* Prejudice and cultural preferences can be obstacles to successful caregiving relations, raising questions about “cultural competence” and management practices to ease the transition to a new culture.
- *Do Migrants Depress Wages and Undermine Working Conditions?* From the perspective of unions and professional associations, employing foreign workers undermines efforts to improve wages and working conditions for nurses and aides. The evidence is mixed; foreign long-term care workers are more likely to take jobs in less desirable locations, but they earn more on average than their native-born counterparts.
- *What Responsibility Do Developed Countries Have for the Impact on Source Countries?* Importing large numbers of health care workers to work in long-term care settings can have negative consequences for the source countries, but different solutions are required to address the specific situations in the countries losing such workers.

IX. Conclusions

Meeting the long-term care needs of the older populations in more developed nations, as well as the economic development and health care needs of less developed nations, will require more engagement across international boundaries. The quality of the long-term care received by older persons in developed countries will depend increasingly on the quality of the engagement with the less developed countries that are likely to supply more of the workers in the future. An array of policy options, programs, and international arrangements will have to

be flexible and tailored to fit the very different needs of each country. Policies and programs that address perceived needs at the national and international levels cannot ignore the individual needs and aspirations of both those who need long-term care and those who would provide that care.

I. Introduction—Long-Term Care Workforce: A Crisis in the Making?

The theme of the Filipino Nurses' Hymn, "We shall travel on," was originally meant to inspire newly trained nurses to travel to remote locations to bring health care services to underserved regions of the country (Choy, 2003). But the phrase has taken on new meaning as increasing numbers of Filipino nurses have left the country, with their government's encouragement, for employment in the United States, the Middle East, and the European Union (EU). In recent years, 70 percent of nurse graduates in the Philippines have "traveled on" to other countries, joining an army of more than 15,000 nurses who leave the country each year (Bach, 2003). Similar scenes are playing out in India, China, sub-Saharan Africa, the Caribbean, and the Pacific Islands as tens of thousands of nurses leave their homelands each year to work in the developed countries of North America, Europe, and Oceania. The overwhelming majority of these migrating nurses are women, and many end up providing long-term care services to the aging populations in developed countries.

Migration to provide services to frail older persons is not restricted to skilled professionals. Increasing percentages of the nurse aides in long-term care settings in the United States come from the Caribbean, Mexico, Africa, and the Philippines. Public cash benefits to persons with disabilities in Austria and Italy have helped fuel a large influx of live-in domestic workers who supplement family caregiving in those nations, though often in a gray economy characterized by illegal immigration or work status. The most intimate care to frail older persons in developed countries is increasingly likely to be provided by young women whose native language, race, and culture are different from those they serve.

The migration of long-term care workers is part of much larger changes associated with the globalization of the world economy and its labor markets. Modern technology has vastly increased the international mobility of ideas, skills, production, and people. But unlike job outsourcing of information technology tasks (Friedman, 2005) or relocation of manufacturing jobs from developed to developing countries (Rivoli, 2005), long-term care involves what Friedman (2005, p. 238) has called "anchored" jobs "because they must be done in a specific location, involving face-to-face contact with a customer, client, patient, or audience." The hands-on work of long-term care necessarily requires workers on location. Since outsourcing frail older persons for care is not a likely option, the pressure to employ international workers will mount in countries where the domestic labor markets cannot fill the jobs.

Holzer (2003, p. 1) begins his discussion of ways to model future demand for long-term workers with the observation: "Of course, economists generally believe that market forces tend to eliminate shortages in the labor market (or elsewhere), especially with the passage of time." Under this "neoclassic" model (Howe and Jackson, 2005; Rauhut, 2004), the demographic aging of developed countries is creating increased demand for long-term care services in excess of what the diminishing supply of native workers can provide. Developing countries have an excess supply of low-cost workers who can supply the needed labor. According to this model, developed countries benefit from more and lower-cost services, and developing countries benefit from providing career opportunities to the excess supply of workers they cannot employ.

But the factors shaping international long-term care labor markets are much more complex than this simple version of the neoclassical approach suggests. The report explores these complex issues and the implications they have for public policies regarding long-term care, immigration, and international economic development. Part IV of the report examines demographic, economic, and social factors that are driving increased international migration of long-term care workers to developed countries. Part V explores the ways that policy decisions regarding long-term care financing, immigration, credentialing, and recruitment affect the numbers and types of workers who migrate. Part VI provides snapshots portraying the various ways that these factors play out in select developed countries. Part VII shifts the perspective to the effects of migration on the source countries in the developing world. Part VIII raises policy questions that must be dealt with by individual countries as well as by international organizations concerned with meeting the needs of both developed and developing countries.

The conclusion reminds us that the macroissues of global and national trends driving change in migration patterns and service delivery are experienced very differently from the microperspective of individual workers and clients whose lives have been brought together by these global changes. In short, the diversity of factors driving the migration of long-term care workers and the scarcity of data related to many of the issues militate against simple solutions that apply to all situations. But now is the time to identify the issues and the data that inform them to promote dialogue between the developed countries that receive long-term care workers and the countries from which they come.

II. Purposes

The purposes of the report are to:

1. outline factors that shape international labor markets for long-term care workers, including demography, skill levels, gender and race, and historical and geographic relationships;
2. describe how policy decisions regarding long-term care financing, immigration, credentialing, and recruitment affect long-term care labor markets;
3. provide brief snapshots of how international labor markets affect the provision of long-term care in select developed countries;
4. report patterns of migration among health and long-term care workers from developing countries and the effects of this migration on the provision of health care and economic development in those countries;
5. summarize how the growing use of international workers affects the quality of long-term care services and outline policy decisions that may affect quality; and
6. examine in depth the use of foreign-born workers in long-term care settings in the United States, included in Appendix B.

III. Methodology

Conducting research on the migration of long-term care workers presents a number of methodological challenges. First, the labor markets for long-term care workers are not entirely distinct from other labor markets, most notably those involving health-related services. While data often exist on the migration of skilled nurses because of the credentialing processes they must go through, these data rarely identify the numbers of foreign-trained nurses who work in long-term care settings. For unlicensed aides or undocumented domestic workers, the data are much sparser and harder to compare internationally.

Even where data exist, Diallo (2004, p. 601) notes that they are “are neither complete nor fully comparable, they are often underused, limited (in that they often provide only broad information on the phenomena associated with migration) and not timely.” To cite one issue, U.S. census data categorize people according to whether they are “foreign born,” largely because U.S. citizenship rights are related to place of birth. But most countries link citizenship to ethnicity rather than place of birth, which affects the data they collect (OECD, 2005b). For example, hundreds of thousands of ethnic Germans migrated to Germany after the demise of communism in Eastern Europe. Such migrants receive automatic citizenship and are characterized as Germans in the country’s data systems, but ethnic Turks who have lived for generations in Germany often do not have citizenship there and are characterized as “foreign.” The 2004 report on migration from the Organization for Economic Co-operation and Development (OECD, 2005b) makes major strides in distinguishing data on “foreign” from data on “foreign-born” to give a more accurate picture of international migration patterns.

While data limitations make a complete picture of international migration patterns of long-term care workers impossible, this report uses three methods to piece together what can be learned from existing data and what gaps remain in our knowledge base. The first is a review of the disparate literature on migration patterns, the demography of developed and developing countries, and international comparisons of long-term systems and immigration policies. Much has been written about international migration, and some research addresses the issues surrounding the migration of health care workers. But little research has looked specifically at the international migration of long-term care workers. Nonetheless, a review of these broader issues is critical, since they form the context for understanding the migration of long-term care workers.

The second method of analysis involves extracting data from databases and studies from international and national organizations. For example, the review of international demographic trends in Section IV draws heavily from the enormously valuable database assembled by the United Nations Population Division. Similarly, data on general international migration trends largely come from the OECD’s annual series, “Trends in International Migration.” Data from national agencies in various countries are used to describe trends in hiring international workers or the loss of workers from developing countries. Private sources of information, such as surveys by the National Council of State Boards of Nursing and the Council of Graduates of Foreign Nursing Schools, have provided more specific information about foreign-trained nurses.

The third method employed original analyses of trends in the employment of foreign-born nurses and nurse aides in long-term care settings in the United States, using U.S. Census and American Community Survey data. The results, which are reported in Appendix B, illustrate some of the data limitations in this area. One drawback of the census data is that they identify long-term care workers by place of birth, not by place of training. Some foreign-born workers undoubtedly received their training in the United States. Also, the data probably understate the number of Canadian workers, because many continue to live in Canada but work in the United States. Finally, the analysis of long-term care workers is restricted to those who work in nursing homes or non-nursing residential care facilities. Nonetheless, the census offers the most complete data on the numbers and demographic characteristics of foreign-born health and long-term care workers in the United States, their countries of origin, locations of work, income, and facility with English. More detailed descriptions of the methods used in the Census analyses can be found in Appendix A.

IV. Demographic, Economic, and Social Factors Shaping International Labor Markets and the Migration of Long-Term Care Workers

The following sections examine the interplay of demographic, economic, and social factors that shape international labor markets for long-term care workers, including:

- Demographic Trends
- Skill Levels and Working Conditions
- Gender and Race
- Historical and Geographic Relations

A. Demographic Trends

Discussions about the shortage of health and long-term care workers in more developed countries frequently cite demographic trends as the cause. Such discussions emphasize the structural and long-term nature of a growing shortage of workers. The demographic challenge is portrayed as twofold: 1) an aging population demanding more long-term care services, and 2) a diminishing supply of workers (mostly women) to fill the jobs associated with long-term care. For example the Royal College of Nurses in Australia (2004, p. 3) notes, “By 2042, around 24.5 per cent of Australia’s population is expected to be aged over 65. At the same time, growth in the population of the traditional workforce age 16 to 64 is expected to slow to almost zero.” Friedland (2004, p. 1) notes a similar situation in the United States: “[A]fter 2015 the number of people likely to need long-term care will increase substantially faster than the number of people available either as family or as paid caregivers. Families will need more support to supplement their efforts and more paid caregivers will be necessary to provide this support.”

Fertility rates below replacement levels, combined with increased longevity, are rapidly changing the age structures of developed countries (Wattenberg, 2004). The number of

working-age people is declining in many developed countries at the same time that the number of older persons at heightened risk of needing long-term care services is increasing rapidly. These trends are likely to accelerate in the coming decades. Holzmann and Muenz (2004) cite projections that the working-age population will decrease by 19.5 percent in Western and Central Europe by 2050, while the older population will increase by as much as 50 percent. Table 1 contrasts projected changes in the working-age and older populations in select developed countries.

Table 1: Projected Changes in Population Characteristics in Select Developed Countries between 2005 and 2050

| | Projected Population Change 2005–2050 | | Percentage of Population Age 80+ | |
|------------------|---------------------------------------|---------|----------------------------------|-------|
| | Age 15–64 | Age 65+ | 2005 | 2050 |
| Australia | +19.9% | +159.5% | 3.4% | 8.9% |
| Austria | -23.4% | +63.7% | 4.4% | 13.9% |
| Canada | +9.4% | +159.2% | 3.5% | 10.5% |
| Germany | -24.9% | +44.1% | 4.4% | 13.3% |
| Italy | -38.6% | +55.9% | 5.1% | 16.6% |
| Japan | -38.2% | +59.4% | 4.8% | 16.7% |
| Norway | +5.0% | +90.6% | 4.7% | 9.7% |
| Spain | -32.5% | +104.5% | 4.1% | 13.5% |
| Sweden | -4.8% | +59.8% | 5.3% | 10.3% |
| UK | -1.2% | +63.3% | 4.4% | 9.2% |
| US | +27.2% | +122.1% | 3.6% | 7.0% |

Source: AARP PPI analysis of United Nations Population Division online data (2004 revisions). These data assume a constant fertility rate.

The relationship between aging and disability has led to projections of increased demand for long-term care services—and the workforce to provide them—over the next few decades. For example, the German Federal Ministry of Health and Social Security (2005) estimates that the number of persons requiring long-term care in Germany will increase by 63.5 percent between 2002 and 2030, from 1.89 million to 3.09 million. For the European Union (EU) as a whole, Przywara (2005) projects that long-term care expenditures will nearly double as a percentage of the gross domestic product (GDP), from 1.3 percent to 2.3 percent, between 2000 and 2050.

The U.S. Department of Health and Human Services (2003) cites projections that the number of workers providing such services (including nurses, aides, and personal care workers in institutional and home-based settings) will grow from 1.9 million to 2.7 million, a 45 percent increase between 2000 and 2010. Looking further into the future, the demand for long-term care workers may increase to between 3.8 million and 4.6 million by 2050—a 100 percent to 140 percent increase over 2000 levels. The U.S. population age 15–64 is only projected to increase by 27.2 percent between 2005 and 2050 (see Table 1). The Health Resources and Services Administration (2004, p. 6) notes that shortfall may be especially critical for aides and other paraprofessional workers since “The pool...from which such workers have

traditionally been drawn—largely women between 25 and 50 without post-secondary education—continues to shrink.”

Two caveats are required when reviewing demographic arguments about the demand for long-term care services and workers. First, demography is not necessarily destiny when it comes to predicting the demand for long-term care services (Friedland and Summer, 1999; Redfoot and Pandya, 2002). Past projections have often overstated future demand for long-term care services, and developed countries differ substantially in disability rates and trends (Robine, Jagger, and van Oyen, 2005) as well as in their use of institutional and home and community-based services (Gibson, Gregory, and Pandya, 2003). Second, as Table 2 indicates, demographic trends related to potential demand for services and workers differ greatly from country to country. For example, the dependent population is projected to nearly equal the working-age population in Japan by 2050. At the other end of the spectrum, the total dependency ratio¹ in the United States is projected to be somewhat less in 2050 than it was in 1960. Even the old age dependency ratio² is only projected to rise to a level comparable to that experienced today in Japan.

Table 2: Old Age and Total Dependency Ratios in Select Developed Countries

| | Old Age Dependency Ratio | | | Total Dependency Ratio | | |
|------------------|--------------------------|------|------|------------------------|------|------|
| | 1960 | 2005 | 2050 | 1960 | 2005 | 2050 |
| Australia | 14 | 19 | 41 | 63 | 48 | 66 |
| Austria | 18 | 25 | 58 | 52 | 48 | 77 |
| Canada | 13 | 19 | 45 | 70 | 44 | 68 |
| Germany | 17 | 28 | 54 | 49 | 49 | 73 |
| Italy | 14 | 30 | 75 | 52 | 51 | 93 |
| Japan | 9 | 30 | 77 | 56 | 51 | 96 |
| Norway | 18 | 23 | 42 | 59 | 53 | 68 |
| Spain | 13 | 24 | 72 | 55 | 45 | 92 |
| Sweden | 18 | 26 | 44 | 51 | 53 | 68 |
| UK | 18 | 24 | 40 | 54 | 51 | 64 |
| U.S. | 15 | 18 | 32 | 67 | 49 | 63 |

Source: United Nations Population Division online data (2004 revisions)

Demographic explanations are more convincing regarding potential future shortfalls of long-term care workers than they are about current shortages in most countries. The total dependency ratio is lower today than it was in 1960 in nearly all developed countries due to the large number of post-World War II baby boomers in the labor market and lower fertility rates. Women’s increased labor force participation complicates family caregiving but has also increased the traditional pool of potential long-term care workers. While demography may be starting to play a role in creating shortages, one must look to a more complex array of economic and sociological factors, some of which are examined below, to explain labor shortages in developed countries.

¹ Total dependency ratio is reported in numbers of persons aged 65 and older plus those aged 14 and younger for every 100 persons 15–64.

² Old age dependency ratio is reported in numbers of persons aged 65 and older for every 100 persons 15–64.

B. Skill Levels and Working Conditions

Labor market characteristics and working conditions are important factors in understanding migration patterns of long-term care workers. Three points must be made at the outset in describing long-term care markets. First, long-term care does not constitute one labor market but at least three relatively distinct markets, each with its own dynamics:

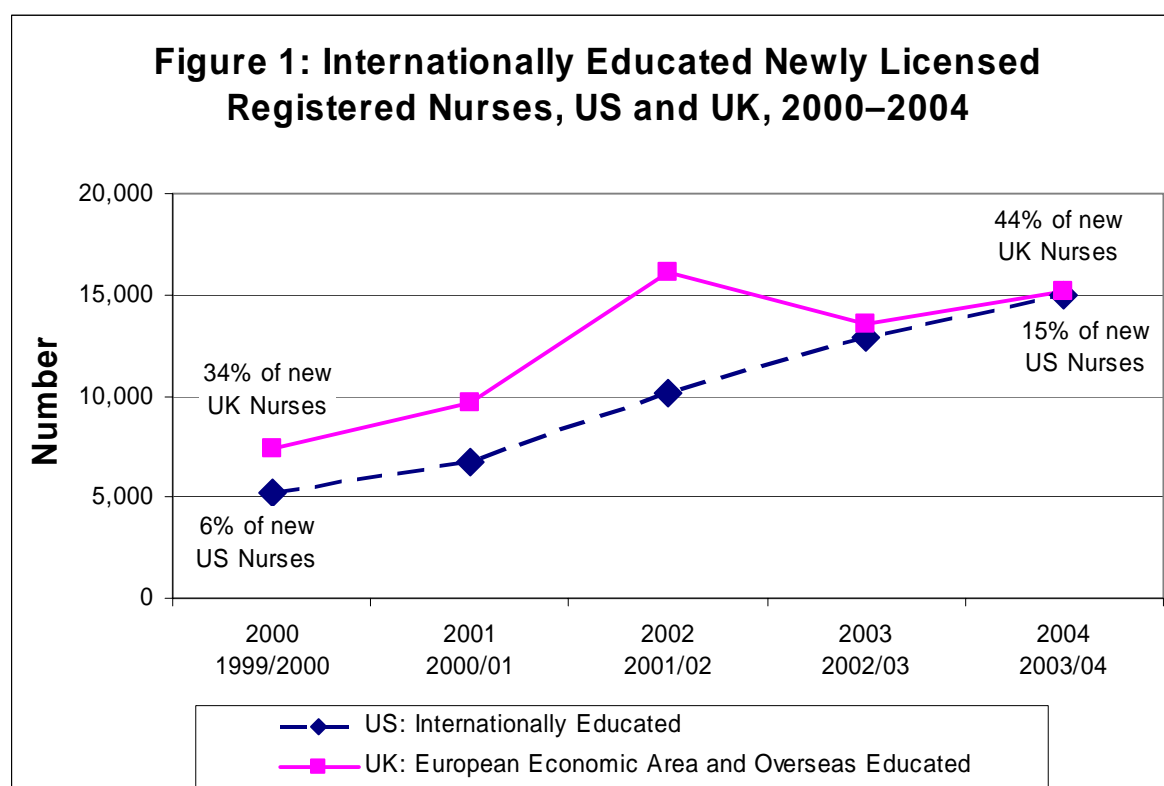
- Skilled workers, such as registered nurses, must navigate complex systems of credentialing to practice their professions after immigrating.
- Unlicensed low-skill aides and other long-term care workers rarely immigrate to pursue a career in health or long-term care, but they find such jobs and training after immigrating. Also in this group may be operators of small group homes for people with disabilities.
- Domestic service workers, many of whom operate in the “gray economy,” constitute a large segment of caregiving in many developed countries.

The skill mix in demand in any one country is the result of economic, demographic, political, and cultural factors that affect the preferences for care and the options available. Because of the credentialing processes involved, more data are available about licensed workers, even though the bulk of caregiving is generally done by unlicensed and domestic workers.

Second, long-term care labor markets are not entirely distinct from health and other services. Registered nurses are not credentialed for long-term care only, so movement among nursing home, home health, and hospital care is quite common. At the other end of the skill spectrum, turnover among unskilled workers in institutional or home settings can be very high (Health Resources and Services Administration, 2004), one indicator that such workers often move to and from jobs in a variety of service industries as opportunities arise. Because the markets, the credentialing, and the data gathering are not distinct, this report often relies on data related to broad categories of workers. Data specific to workers in long-term care settings are noted.

Third, the migration of long-term care workers is part of broader trends driving migration patterns and policies. Migrants to developed countries tend to be overrepresented among workers with the highest and lowest levels of education and skills (Doudeijns and Dumont, 2003). In the EU, 20 percent of the foreign-born population has high skill levels, compared to 17 percent of the total population. At the other end of the spectrum, low-skill workers comprise 52 percent of the foreign-born population, compared to 48 percent of the total population (Muenz and Straubhaar, 2004). Much of the attention has been on the migration of highly skilled workers, because immigration laws in developed countries encourage such migration and because of concerns about the potential for the “brain drain” of skilled workers from developing countries. The absolute number of highly skilled immigrants in the United States, 8.2 million, dwarfs all other nations. Canada is second with just over two million (OECD, 2005b).

Health care-related immigration follows a pattern similar to that of general migration, with demand greatest for physicians and nurses at the highly skilled end and for nurse aides at the lower skill end (Lowell and Gerova, 2004). One-quarter (24 percent) of the work permits issued for immigration to the UK were for skilled health and medical workers, the largest category for such permits (Sriskandarajah, 2004). Indeed, half (51 percent) of the increase in physicians in the UK between 1993 and 2003 came from doctors qualified overseas (Sriskandarajah, 2004). Similarly, nearly half of all newly registered nurses in the UK in recent years have been foreign trained. Figure 1 shows the increasing percentages of foreign-trained nurses in the UK and the United States, two of the biggest importers of skilled nurses in recent years.



Sources: Online data from the U.S. National Council of State Boards of Nursing (NCSBN) and the Nursing and Midwifery Council of the UK

Long-term care migration shares many characteristics with the migration of other health care workers. However, the relatively lower prestige and working conditions associated with long-term care are undoubtedly factors in the disproportionate numbers of migrating health care workers finding work in long-term care settings. For example, 14 percent of foreign-trained nurses work in private nursing homes in the UK, compared to 5 percent of UK-trained white nurses. In total, nurses who were first qualified overseas are twice as likely to work in “older people’s nursing” as those who were first qualified in the UK (27 percent compared to 13 percent [Royal College of Nursing, 2002]). U.S. data, which report foreign-born rather than foreign-trained, reveal that the number of foreign-born nurses in long-term care settings increased by more than sixfold between 1980 and 2003, and their percentage more than doubled in the same period, from 6 percent to 16 percent (see Table B3, Appendix

B). Foreign-born nurses earn substantially less income in long-term care settings than in other health care settings. Foreign-born nurses and nurse aides in long-term care facilities are somewhat younger, more recent immigrants, and more likely to be black than are their foreign-born counterparts in other health care settings (see Table B14, Appendix B). These data may reflect the relatively lower status of long-term care among health care workers, where work in a long-term care setting is an entry-level job that workers leave when better opportunities present themselves.

C. Gender and Race

Gender issues permeate all aspects of long-term care, from unpaid family caregiving to international labor markets for skilled care. The fact that caregiving, paid and unpaid, is seen as “women’s work” suggests that “dual labor market” theories may offer more explanatory value than does the “neoclassic” emphasis on pure market forces (Howe and Jackson, 2005). Dual labor market theory often focuses on how markets are segmented by class in ways that become self-perpetuating. In the case of long-term care, the labor market is segmented by the interacting factors of gender, ethnicity, and class. At all levels of long-term care services, a system is evolving in more developed countries where much of long-term care is provided by women of color from other countries.

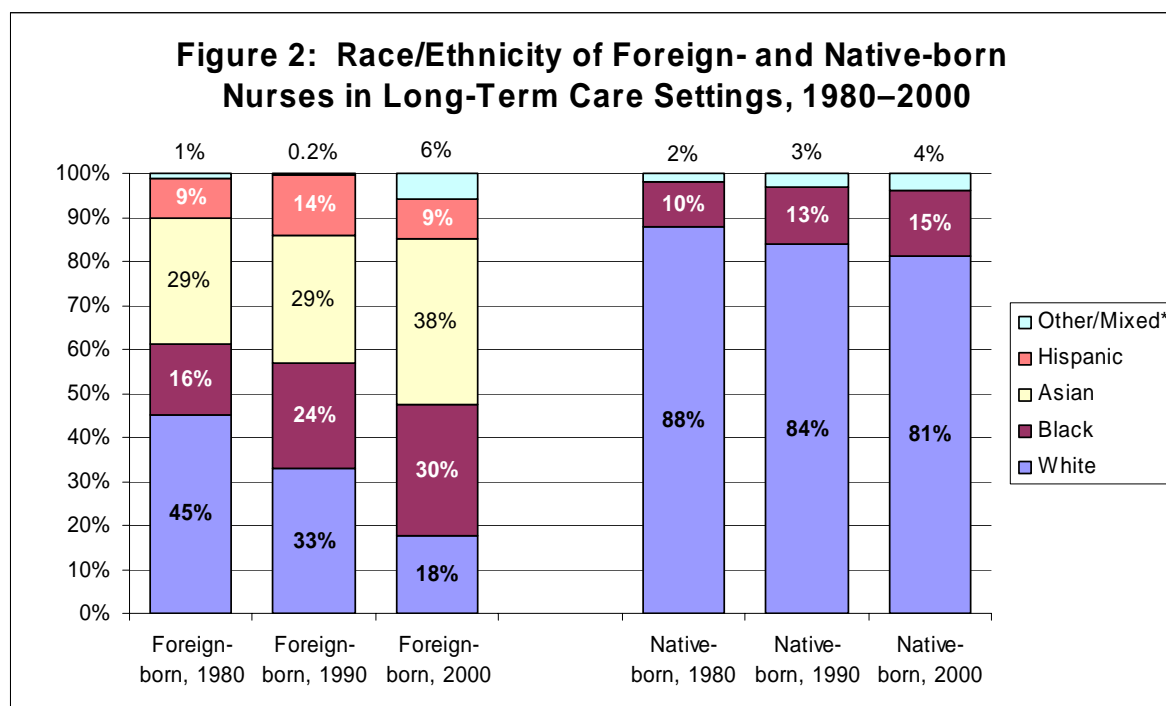
Family caregiving is the first source of long-term care in every country, and women are generally the primary caregivers. Changing gender roles in developed countries have created a demand for more support in the home to replace the caregiving roles female family members traditionally provided. Increasing numbers of families are drawing on international workers, overwhelmingly women, to provide the support (Van Eyck, 2004). In their study of Italian caregiving, Polverini and Lamura (2004) note that low-skill immigrant women are often the only ones willing to provide the round-the-clock, live-in help needed to replace traditional family caregiving.

Bettio et al. (2004) note that breakthroughs in the gender-based dual labor markets have created employment opportunities for native-born women in more developed countries, while creating openings for foreign-born women to provide caregiving. Public policy often reinforces the traditional responsibilities of gender-based caregiving to meet long-term care needs. In Italy the changing roles of women have combined with public policies that emphasize family responsibility for care to create a huge gray market for female migrants to provide in-home care (Polverini and Lamura, 2004). As Bettio et al. (2004, p. 7) note, “In less than a decade there has been a large scale substitution between ‘native female family members,’ providing unpaid work, and ‘female migrants,’ providing cheap and flexible paid work for the care of the elderly members of an ageing society. Paradoxically, ... ‘economic emancipation’ [is] the factor behind the behaviour of both Italian women and female migrants coming to Italy on their own.”

The low wages and poor working conditions for aides and care assistants in most countries also point to the existence of dual labor markets for those employed in institutional or agency-based long-term care. Harris-Kojetin et al. (2004) note that high turnover rates and vacancies exist for direct caregivers in many countries even under conditions of relatively high unemployment rates, which cannot be explained by neoclassic theories or by

demographic arguments emphasizing structural shortages due to the aging of the population. They point to poor wages and working conditions that attract only marginal or entry-level workers. Increased employment opportunities for women who might otherwise be in the traditional pool of long-term care workers compound the shortage, creating openings for low-skill immigrants who are willing to do work that native-born women are not willing to do.

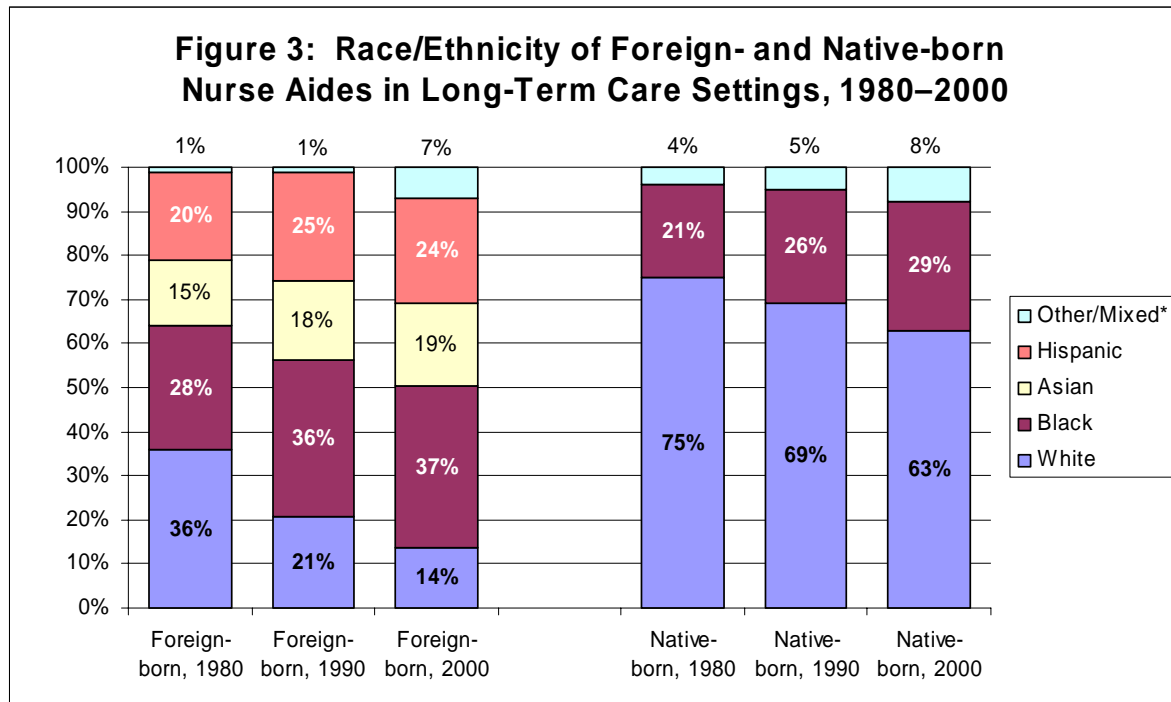
Evidence of a dual labor market exists even at the professional level. Women interested in pursuing careers in the more developed countries are increasingly turning to options other than nursing, contributing to shortages and morale problems in that profession. Nurse associations around the world describe their profession as one in crisis because of working conditions and low morale (Gordon, 2005; Royal College of Nursing, 2002; Aiken et al., 2001). Spratley et al. (2000) report that among all nurses in the United States, only 69.5 percent expressed satisfaction with their jobs, compared with 85 percent of all workers and 90 percent of other professionals. Nurses in nursing homes revealed the lowest level of satisfaction among all settings, with only 65 percent expressing satisfaction. Turnover rates of over 50 percent among nurses in many U.S. long-term care settings reflect this low morale (National Commission on Nursing Workforce for Long-Term Care, 2005). Declining satisfaction with the practice of nursing leads to declining enrollments in nursing schools, thus perpetuating the cycle of shortages and low morale (Spratley et al., 2000).



*For native-born nurses, includes native-born Hispanic and Asian nurses, as the percentage of native-born nurses who are Hispanic or Asian is very small. Source: U.S. Census data, AARP PPI analysis.

The dual labor market that has traditionally characterized employment opportunities for native-born women in developed countries is now being internationalized. The internationalization of these labor markets has racial as well as gender implications. As other opportunities open, native-born women, especially whites, are not entering the caregiving professions at the same rate as the past in the United States (George, 2005). Between 1994

and 2002, the number of native-born nurses in the United States younger than age 35 declined from roughly 490,000 to 380,000 (Arends-Kuenning and McNamara, 2004). Declining numbers of native-born nurses open opportunities to women from developing countries where nursing may still be one of the few professional opportunities available. The result is that nurses and aides in long-term care settings are increasingly likely to be women of color, both foreign and native born, as demonstrated by the data in Figures 2 and 3.



*For native-born nurse aides, includes native-born Hispanics and Asians, as the percentage of native-born nurse aides who are Hispanic or Asian is very small. Source: U.S. Census data, AARP PPI analysis

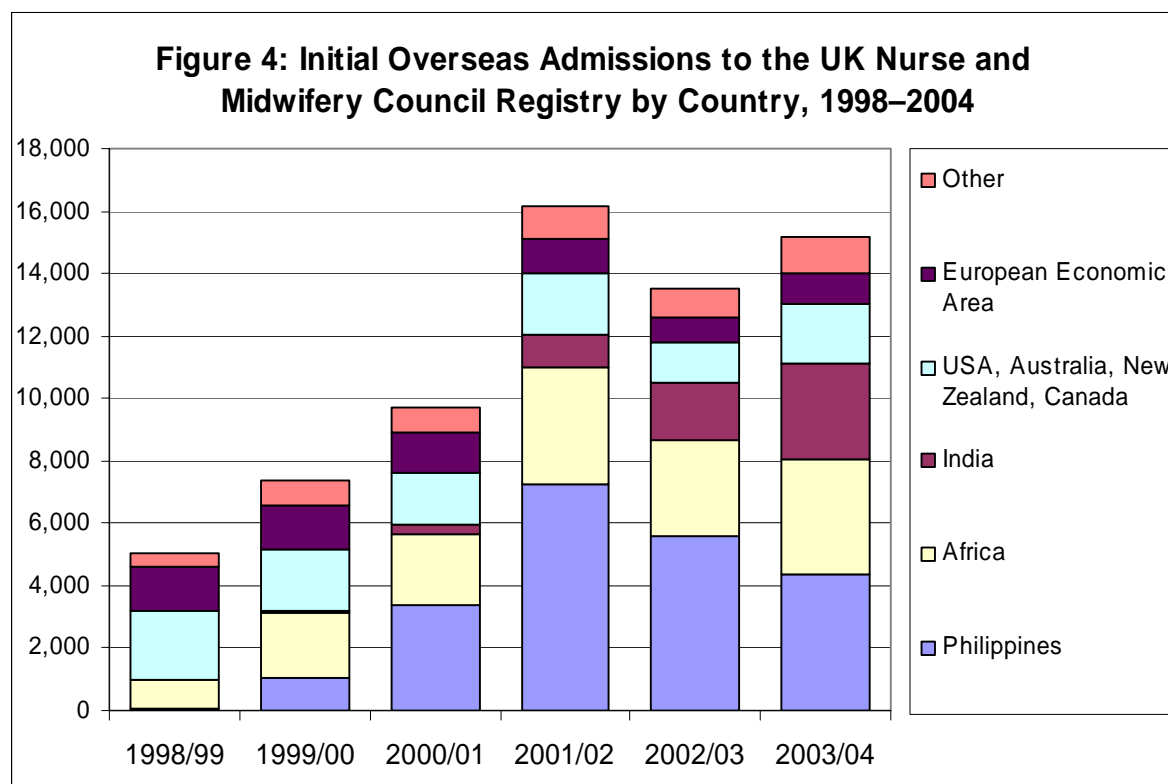
D. Historical and Geographic Relations

Histories of colonialism and geographic proximity also play major roles in patterns of migration. An example of the influence of a colonial past is the migration of nurses from the Philippines to the United States. Choy (2003) notes that the colonial history of the first half of the 20th century laid the foundation for the migration that followed in the second half of the century. She describes four characteristics of nurse training established during the colonial period that continue to shape the migration of nurses to this day: 1) Americanized professional nursing training, 2) English-language fluency, 3) Americanized nursing work culture, and 4) gendered notions of nursing as women's work (p. 41).

Much the same can be said for the relationship between European countries and their former colonies. The education systems in former colonies often teach in the language of the colonial power and track its educational requirements, which can ease migration from former colony to colonizer. Immigration rules may also be eased because of the historical relationship. For example, many health care workers have migrated from former Portuguese

colonies in Africa to Portugal (Stilwell et al., 2004), and many Latin American caregivers, often operating in the gray economy, provide services in Spain (Johansson and Moss, 2004).

Immigration of nurses to the United States and the UK has shifted dramatically in recent years from developed countries to developing countries. The former American colony, the Philippines, continues to be the largest supplier of registered and practical nurses in the United States (Arends-Kuenning and McNamara, 2004; see also Table 7 below). Between 1990 and 2000, Nigeria (with 343 percent growth), Mexico (100 percent growth), and Haiti (125 percent growth) joined the top 10 providers of foreign-born registered nurses to the United States, as Ireland and Germany declined in relative importance (Arends-Kuenning and McNamara, 2004). As Figure 4 shows, the number of newly registered nurses in the UK who were foreign trained tripled between 1998/99 and 2003/2004, from 5,034 to 15,132. During the same period, the proportion of new nurses who came from developed countries in the EU or from Australia, New Zealand, United States, and Canada declined from 72 percent to 19 percent. With the major exception of the Philippines, virtually all of the increase in foreign-trained nurses in recent years has come from former colonies in Africa and Asia (Nursing and Midwifery Council, 2005). These nurses sometimes note that they came to the UK because of the colonial history and British-based education system that they thought would ease their transition (Allan and Larsen, 2003).



Source: Online data from the UK Nursing and Midwifery Council; AARP PPI analysis

Regional proximity also plays an important role in the migration patterns of long-term care workers. Among low-skill aides and domestic workers, Ungerson (2004) notes that many temporary caregivers come from Hungary and Slovakia to Austria for short, rotating terms.

Among skilled nurses, nearly all of the foreign-trained nurses in Austria are from European countries, with 70 percent coming from the nearby countries of Bosnia, Romania, Croatia, Czech Republic, and Poland (Simoens, et al, 2005). Similarly, 60 percent of foreign-trained nurses in Switzerland come from the nearby countries of Germany, Bosnia, France, Albania, and Italy, and most of the rest come from other European countries (Simoens, Villeneuve, and Hurst, 2005).

U.S. data indicate that skill level is a major factor shaping international migration patterns of long-term care workers. The labor market for foreign-born skilled nurses tends to be global, while the labor market for foreign-born nurse aides tends to be more regional (see Table 3; see also Arends-Kuenning and McNamara, 2004, for a discussion of these patterns).

Table 3: The Number and Percentage of Foreign-Born Nurses and Nurse Aides in Long-Term Care Settings in the United States from the Top Five Countries of Origin, 2000

| Nurses | | Nurse Aides | |
|-----------------------|--------------|--------------------|--------------|
| Philippines | 12,500 (25%) | Jamaica | 14,500 (13%) |
| Jamaica | 4,800 (9%) | Philippines | 13,300 (12%) |
| Haiti | 3,300 (7%) | Mexico | 12,800 (11%) |
| India | 3,100 (6%) | Haiti | 11,700 (10%) |
| United Kingdom | 1,860 (4%) | Puerto Rico | 4,800 (4%) |

Source: U.S. Census, 2000, AARP PPI analysis

V. Policy Decisions and the International Migration of Long-Term Care Workers

Policy decisions also play a major role in the volume and patterns of international migration to provide long-term care. Sometimes the effects of policy decisions are direct and intentional, but just as often, the effects are indirect and unintentional. The following sections look at the impact on the migration of long-term care workers of policy decisions in the following areas:

- Long-Term Care Financing
- Immigration and Naturalization
- Education and Credentialing
- Worker Recruitment

A. Long-Term Care Financing Policies

Long-term care financing policies both reflect and reinforce service delivery models and traditions of family responsibility, which affect the demand for various types of workers. Esping-Andersen (1990) suggested a typology of three kinds of welfare state policies in Europe that relate to how services are delivered and by whom. The “social democratic regime,” most in evidence in Scandinavian countries, provides universal coverage and

professionally delivered services designed to support employment for the whole adult population—especially women. A second approach is the “conservative-corporatist welfare regime,” which provides substantial social benefits, along with strong incentives for women to continue family caregiving roles (e.g., Germany, Austria, and France). A third approach, which Esping-Anderson refers to as “liberal welfare regimes,” provides only moderate benefits that are usually means tested (e.g., UK). Bettio et al. (2004) note that a distinct “Mediterranean model” offers low public support of long-term care services and relies heavily on traditional family caregiving.

The degree of cash versus agency funding is an important emerging issue in the public financing of long-term care, along with the related issues of regulatory oversight of care options. A recent OECD (2005a) report notes an international trend toward more cash benefits to support more consumer choice and control over service options. But the decision to emphasize cash benefits or agency-based services affects more than consumer choice; it also affects family caregiving responsibilities (Jenson and Jacobzone, 2000) and the use of immigrant workers. Lundsgaard (2005) and Ungerson (2004) note that public support for agency-based services (as in Scandinavian countries) results in high levels of professional services and low use of international workers. At the other end of the spectrum, cash benefits with few restrictions place more of the caregiving responsibility with families (Jenson and Jacobzone, 2000). One solution for women caught in the conflict between increased caregiving responsibilities and careers is to hire low-skill and undocumented international workers for support (e.g., in Italy and Austria).

Small group homes staffed by low-skill service providers have also opened employment opportunities for recent immigrants in some countries. For example, when the state of Oregon (United States) opened means-tested funding to small group homes, Romanian immigrants set up a network to provide those services and now dominate that market niche (National Health Policy Forum, 2001).

B. Immigration Policies

Immigration policy debates are very contentious in many countries, relating not only to meeting changing labor market demands but also to maintaining the cultural and ethnic heritage of their nations. Even in the face of demographic challenges, most developed countries have been very reluctant to open their doors to greater immigration. Indeed, political sentiments and policies against increasing immigration may rise in response to these demographic changes in the native population, as voters fear the increased role that immigration is having in transforming their societies (UN Population Division, 2000). Only the United States, Canada, Australia, and New Zealand have been generally open to permanent immigration, which has affected not only their long-term care workforces but also contributes to the relative youth of their societies compared to other developed countries.

The OECD (2005b) notes three trends in international migration of particular relevance to long-term care workers: 1) a general “toughening” of policies to control immigration flows; 2) international coordination for better control of irregular immigration; and 3) use of selective employment-based policies that facilitate the permanent or long-term immigration of highly skilled workers, while limiting low-skill workers to temporary or seasonal entry.

Consistent with the focus on promoting highly skilled immigration, a number of countries, including the United States and the UK, have instituted special visa incentives for skilled health care workers.

Unilateral policy decisions by individual countries, as well as multilateral or bilateral agreements among countries, are used to control immigration (OECD, 2004a). One of the most extensive multilateral agreements is the EU's open migration among its member states. The expansion of EU membership to 10 new countries has opened the doors to greater freedom of movement and residence from these countries to the 15 countries already in the EU (Jandl and Hofmann, 2004). However, most of the original 15 countries continue to restrict access to their labor markets under the terms admitting new member states. Freer movement without opening legal work opportunities has already increased short-term and generally extra-legal work opportunities for in-home caregivers in countries like Austria and Italy (Ungerson, 2004; Polverini and Lamura, 2004).

In addition to multilateral agreements, many bilateral agreements have been negotiated (Stilwell et al., 2003). Developing countries seek such agreements to open opportunities and protect the rights of emigrating citizens (OECD, 2004a), while developed countries often seek to manage migration and limit extralegal migration (Barbin, 2004; Durand, 2004). Australia and New Zealand, for example, have a bilateral agreement recognizing each others' nursing credentials, which has facilitated the movement of skilled nurses between their countries. After reviewing such agreements, however, Durand (2004) concludes that unilateral immigration policies such as those used in the United States and Canada are more effective than are bilateral agreements in addressing country-specific labor market needs for skilled workers.

Economic globalization and increased demand for low-skill workers conflict with increasingly stringent immigration restrictions on such workers—making illegal or irregular immigration the only avenue for migration (IOM, 2005). Howe and Jackson (2005, p. 1) note that “undocumented or ‘illegal’ entry [is] growing faster than any other type of immigration.” The U.S. population of undocumented immigrants is estimated at more than seven million out of a total foreign-born population of 35 million (OECD, 2005b). These workers are playing a substantial long-term care role in many countries by providing domestic services for older people—albeit in the “gray economy.”

C. Education and Credentialing

Nations establish education and credentialing requirements to help assure quality of care; these requirements can also be used as a method for limiting the admission of long-term care workers, especially skilled workers (Bryant 2005). For example, Japan has some of the most stringent requirements, allowing only graduates of Japanese nursing schools to be licensed (Brasor, 2004). Bilateral negotiations are underway to allow a minimal number of graduates of Filipino and other nursing schools, after demonstrating nursing and language competence, to practice in Japan. But the Japanese Nurses Association strenuously opposes any opening to immigrant nurses (Sieg, 2004).

Educational requirements for long-term care workers differ from country to country and within countries. For example, a registered nurse in the United States can be a graduate of a four-year baccalaureate program, a two-year associate degree program, or a hospital-based program. Part of the shortage problem in the United States is its limited nursing school capacity (Aiken, 2005; Buerhaus, Staiger, and Auerbach, 2004). In 2003–04, at a time when the United States was importing increasing numbers of nurses, Aiken (2005) notes that 150,000 qualified applicants were turned away from the nation’s nursing schools.

The volume of migrating nurses has led to efforts for international recognition of nursing degrees (Bryant, 2005). The most extensive agreement on international recognition is among EU countries, which provides for the mutual recognition of nursing credentials (Bach, 2003), though efforts to promote freer movement of skilled health care workers have had only a very modest impact to date (Simoens, Villeneuve, and Hurst, 2005). Scandinavian countries have allowed the free flow of nurses for more than 20 years (Buchan, Parkin, and Solchalski, 2003). The North American Free Trade Agreement (NAFTA) includes provisions allowing for the temporary employment of health care professionals from Canada, Mexico, and the United States in each of the three countries and has led to discussions about mutual recognition of professional credentials (Bach, 2003). Mode 4 of the General Agreement on Trade in Services (GATS) provides for the temporary provision of health care services across country boundaries, though its impact on migration appears to be limited (Stilwell et al., 2003).

Some have argued that credentialing processes have been motivated as much by the desire to keep foreign workers from practicing their professions as they have been by quality concerns. Choy (2003) traces the development of the U.S. credentialing process, arguing that much of the motivation for establishing the process stemmed from lobbying efforts by the American Nurses Association (ANA) to limit the immigration of nurses. In the 1970s, states began to require a competency test developed by the National Council of State Boards of Nursing, at that time a branch of the ANA. That test evolved into the National Council Licensure Examination (NCLEX®) used to this day to measure nursing competence. Choy notes that the failure rate was very high among foreign-trained nurses in the early years—only 23 percent passed in 1976 (2003, p. 169). Although pass rates have improved substantially, only 58.2 percent of foreign-trained applicants passed the NCLEX-RN® on their first attempt in 2004, compared to 85.3 percent of U.S.-educated nurses (Crawford et al., 2005).

In 1978, the ANA and the National Council of Nurses established the Council of Graduates of Foreign Nursing Schools (CGFNS) to deal with ongoing concerns about the quality of foreign-trained nurses and to stem the number of foreign nurse candidates in the United States who failed the licensing examination (Choy, 2003). The purpose of the CGFNS was to develop prescreening tests of nursing competence and English-language competence before coming to the United States to take the NCLEX® exam. While this prescreening process may protect some foreign nursing students from the problems associated with failing the licensing exam, it also adds another set of requirements and delays to the complicated process of becoming licensed in the United States. As Table 4 indicates, the process of getting through the various levels of pretesting and testing to final licensure takes, on average, nearly two years (22.6 months) and costs more than \$2,500.

Table 4: Time and Cost Required to Complete Steps for U.S. RN Licensure

| | With Recruiter* | Without Recruiter | Total Group |
|--|------------------------|--------------------------|--------------------|
| Average no. of months to receipt of U.S. RN license | 19.3 | 24.8 | 22.6 |
| Average cost | \$2,974 | \$2,251 | \$2,513 |

*Thirty-four and a half percent of respondents reported working with a recruiter. Twenty-one percent of those with a recruiter and 38 percent of those without a recruiter needed to retake the NCLEX® test. The total time to receipt of U.S. RN license averaged 19.2 months for those who passed the first time and 31.4 months for those who had to retake the test. Source: Smith and Crawford, 2004

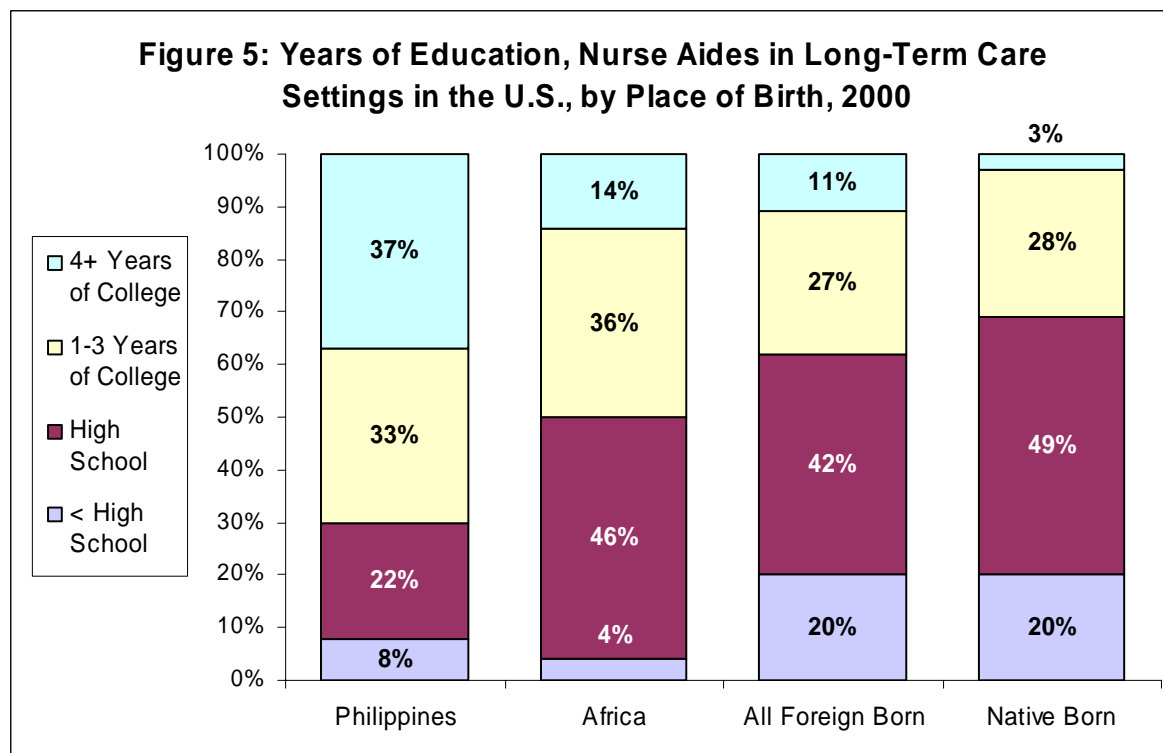
Aiken (2005) notes that 19,903 nurses began the process of applying for the CGFNS prescreening exam in 2001, but only 3,482 received visa screen certificates. Of these, only slightly more than half could expect to pass the NCLEX® exam on their first attempt. The time required for a foreign-trained nurse to be licensed in the United States ranges from less than a year, on average, for applicants from Canada to more than two years, on average, for applicants from Nigeria and the Philippines. Such a lengthy process can cost several thousand dollars, as shown in Table 5.

Table 5: Average Months and Cost Required to Complete Steps for U.S. RN Licensure

| Country of Origin | | | | | |
|---|---------------|--------------|----------------|--------------------|-----------|
| | Canada | India | Nigeria | Philippines | UK |
| Start of process to get SSN | 4.9 | 14.9 | 8.1 | 19.1 | 12.5 |
| Start to complete credential review | 5.9 | 5.4 | 4.6 | 9.4 | 5.8 |
| Start to complete English testing | NA | 10.9 | 8.1 | 13.6 | NA |
| Application for permission to test to 1st NCLEX® test | 5.2 | 5.8 | 5.9 | 5.6 | 4.9 |
| Start to receipt of U.S. RN license | 11.3 | 23.2 | 25.6 | 25.4 | 20.5 |
| Time to achieve license minus time for credential review | 8.8 | 13.8 | 17.5 | 15.4 | 13.3 |
| % Retaking the NCLEX-RN® | 14% | 33% | 60% | 31% | 11% |
| Cost | \$1,145 | \$2,448 | \$1,872 | \$3,087 | \$2,707 |

Source: Smith and Crawford, 2004

One reason given for implementing the prescreening process through the CGFNS was the high failure rate of nurses who came to the United States to take the licensing exam. As McKeon (2003) notes, “Often, these nurses would be employed as lower-paid nurses’ aides.” While no one has documented the exact extent of this “decredentiaing,” it appears to be fairly common for foreign-trained nurses to work for some time as nurse aides while waiting to take or retake the licensing exam (George, 2005). Evidence of decredentiaing comes from the unusually high levels of education among foreign-born nurse aides. As Figure 5 shows, 70 percent of aides from the Philippines and 50 percent of aides from Africa have some college education, compared to only about 30 percent of native-born aides.



Source: U.S. Census data, 2000, AARP PPI analysis

More direct evidence of “decredentiaing” comes from the number of migrating nurses who were educated as registered nurses in their home countries but who have become licensed as practical nurses in the United States. The Commission on Graduates of Foreign Nursing Schools (2005) found that 80 percent of the foreign-educated practical nurses surveyed had been educated and licensed as registered nurses in their home countries. These nurses either failed the NCLEX® exam for registered nurses or their education was considered more comparable to that of practical nurses in the United States. The “decredentiaing” of practical nurses is especially relevant to long-term care, since 50 percent of all internationally educated practical nurses found employment in long-term care settings, compared to only 16 percent of a similar sample of internationally educated RNs (Commission on Graduates of Foreign Nursing Schools 2002, 2005).

British credentialing of nurses relies more on individual determinations and emphasizes serving a clinical trial period rather than competency testing. But this system can be as time-

consuming and difficult as that in the United States. Of 41,406 nurses and midwives who applied for registry in the year ending in March 2004, 3,394 were accepted the first time, and 11,352 were accepted only after a “period of adaptation” (Nursing and Midwifery Council, 2005). During this adaptation period, trained nurses are decertified or “deskilled” and often work as “carers” in care homes for older people until they are judged ready to register as nurses again. Many international nurses report feeling that the adaptation period is arbitrary and exploitative because they are asked to perform many of the functions of a nurse but are not paid at that level (Allan and Larsen, 2003).

D. Worker Recruitment

Selective recruitment affects the migration patterns of long-term care workers, especially among skilled nurses. Faced with the pressures to fill staff vacancies, employers find professional recruiters to be essential links to potential employees without incurring the costs of direct recruitment. From the perspective of migrating workers, recruiters link them to potential jobs and help them navigate the complicated process of immigration and credentialing (see Table 5). A good recruiter is more than a jobs broker, serving also as a consultant to employers on how to integrate foreign workers into their workplaces (Hoppe, 2005).

Some recruiters have come under criticism for ethically questionable practices (International Council of Nurses, 2001), however. These criticisms are of two types. The first is misrepresentation of the types of services they will provide or the pay and work conditions the migrating worker can expect (Choy, 2003; Allan and Larsen, 2003). The second type of criticism is that recruiters try to maximize the number of workers they can enlist with little regard for their impact on health care services in the source country (International Council of Nurses, 2001).

Recruiters are largely unregulated by either the host or source country. Nongovernmental professional organizations, including the International Council of Nurses, have issued codes of ethics. Ethical standards have also been issued by international organizations representing member states such as the Standing Committee of Nurses of the European Union (2005) and the Commonwealth (Commonwealth Secretariat, 2005a). Finally, individual nations have issued guides for the recruitment of nurses (see the Standing Committee of Nurses, 2005, for links to national guidelines). However, a review of eight national and international codes of practice to encourage ethical recruitment of international health care workers found that “support systems, incentives and sanctions, and monitoring systems necessary for effective implementation and sustainability are currently weak or have not been planned” (Martineau and Willetts, in press).

One of the most notable national guidelines was issued by the Department of Health (UK) (2004). Among other things, this code prohibits recruitment of health care professionals from certain less developed countries by the National Health Service (NHS) to stem the “brain drain” of health care professionals from countries that can ill afford to lose them. But the code does not apply to nurses employed in the independent sector. As a result, 10 percent of the non-NHS nurses were first qualified overseas in 2002, compared to 4 percent of NHS nurses. Moreover, foreign-trained nurses were much more likely to work in independent

nursing homes: 14 percent of internationally qualified nurses worked in such settings compared to only 5 percent of white UK nurses (Royal College of Nursing, UK, 2002). In fact, one of every four overseas nurses who were qualified in the UK in 2002–2003 was from countries on the Department of Health’s proscribed list (Buchan and Dovlo, 2004), calling into question the effectiveness of the code as a method of restricting recruitment of nurses from countries facing critical shortages.

South Africa was specifically targeted for relief after an appeal by Nelson Mandela in 1997 to end the recruiting of nurses (Bach, 2003). South Africa and the UK reached a memorandum of understanding to deal with the migration of health care personnel (Mafubelu, 2004). But despite this agreement, and despite South Africa’s being on the proscribed list for recruiters, 5,171 South African nurses were registered in the UK between 2001–02 and 2003–04 (Nursing and Midwifery Council, 2005). By way of comparison, the number of registered nurses in South Africa grew by only 2,163 between 2001 and 2003 (South African Nursing Council, 2005).

Informal recruitment patterns are often more important in establishing patterns of migration than are professional recruitment services. As a UN report notes, “The family is the first link in the chain of entities that will likely support migrants in their journey to their projected destinations” (UN Department of Social and Economic Affairs, 2004, p. 151). In both India (George, 2005) and the Philippines (Choy, 2003), family networks are most important in financing nursing education—often with the expectation that the family investment will be returned by the remittances sent by migrating nurses. So family expectations of migration are often built into the decision to send a daughter to nursing school. The decision to leave home to go far away to nursing school already involves a decision to migrate, even if the school is in the same country; this is particularly clear in multiethnic India where the nursing school may be in an area with a different language, religion, and culture from that of the home area (George, 2005).

Family members who have already migrated can be an important network of support for the migrating nurse. Support often comes as well from the “kith network” (UN Department of Social and Economic Affairs, 2004) of fellow and former students in nursing schools, especially those who have migrated previously (Khadria, 2004). Migrating nurses sometimes use pseudo-kinship terms for their “sisters” who support them in the transition from the country of origin to the host country (George, 2005). These informal networks are sometimes reinforced and used by professional recruiters who facilitate the migration (Choy, 2003).

VI. Snapshots of Migration and Long-Term Care Workers in More Developed Countries

Labor markets for long-term care workers differ among developed countries. The countries discussed below were selected because their differences in demographic characteristics, long-term care financing systems, and immigration policies have resulted in distinctive patterns of migration among long-term care workers. At one end of the spectrum, Japan has some of the most pressing demographic needs but is one of the least open to immigration to provide workers. Norway and Sweden offer extensive publicly provided services that are only

beginning to use international workers. The cash benefits provided in Italy and Austria have encouraged large numbers of home care workers, many operating in the gray economy. The UK and the United States have been among those most open to immigration of international health and long-term care workers, especially skilled workers. Detailed information on the United States is found in Appendix B.

A. Japan

Already with the world's highest median age at 43 years old, Japan's median age is projected to be 52 by 2030 and 56 by 2050 if fertility and immigration rates remain unchanged (UN Population Division, 2005). Japan currently has 30 people age 65 and older for every 100 people 15–64, a number projected to rise to 53 in 2030 and to 77 by 2050. In comparison, the United States currently has 18 people age 65 and older for every 100 people 15–64, which is projected to rise to 32 for every 100 by 2050 or about where Japan is today (UN Population Division, 2005). Despite these demographic pressures, Japan is one of the countries least open to immigration. Only 1 percent of its population is foreign, and Japan naturalized only 14,300 people in 2002 (OECD, 2005b). In a recent poll, 83 percent of Japanese respondents opposed increased immigration by foreign workers (Welford, 2004).

Japan instituted a national social insurance program to cover long-term care in 2000. The program has a number of goals, including relieving the caregiving burden on the growing number of Japanese women who are in the workforce (Mitchell, Piggott, and Shimizutai, 2004). Indeed, when Japan debated the direction of its social insurance program for long-term care, feminists strongly opposed cash benefit proposals because they feared such benefits would reinforce the traditional caregiving responsibilities of daughters-in-law (Campbell, 2002). Roughly 2.5 million people were certified for eligibility in the first year, growing by 45 percent in the first three years (AARP Global Aging Program, 2003). The Japanese Ministry of Health estimates that the number of older people needing long-term care will rise from 2.8 million in 2000 to 5.2 million in 2025 (Mitchell, Piggott, and Shimizutai, 2004). During that same time, the United Nations Population Division (2005) projects that the population age 15–64 will decline by 16 percent.

Despite the projected gap between the demand for long-term care services and the supply of workers, Japan has remained essentially closed to immigration of skilled health care workers. Only 110 foreign “medical service” workers (doctors and nurses) worked in Japan in 2003 (Iguchi, 2005). Japan requires that nurses receive their training at Japanese nursing schools, and only permanent residents are permitted to take the national licensing examination (Hanai, 2004). This requirement may be relaxed somewhat due to international free trade agreements with the Philippines and others. But the recently negotiated free trade agreement allows entry to only 100 Filipinos in the first year, and the Japanese Nursing Association strongly opposes even that level of immigration (Sieg, 2004). Some Filipino domestic workers provide services to older persons (Brasor, 2004), but their numbers are small, and they often work for low wages in a gray economy with few protections.

B. Scandinavian Countries

The Scandinavian countries of Sweden and Norway are somewhat younger and much more open to immigration compared to Japan. Sweden's median age of 40 in 2005 is projected to rise to 44 in 2030 and to 46 by 2050; Norway is slightly younger, with a median age of 38 in 2005 that is projected to rise to 42 by 2030 and to 45 by 2050 (UN Population Division, 2005). Based on these projections, the number of people in Sweden age 65 and older for every person 15–64 will rise from the current level of 26 to 64 in 2030 and to 68 in 2050; Norway will see this “old age dependency ratio” increase from its current level of 23 to 36 in 2030 and to 42 in 2050 (UN Population Division, 2005).

A large percentage of the foreign migration to Sweden and Norway has been among refugees and asylum seekers. In Sweden, 12.0 percent of the population is foreign born, as is 7.3 percent of the Norwegian population (OECD, 2005b). The OECD (2005b) reports that 19.3 percent of the foreign workers in Norway and 20.3 percent of those in Sweden work in the “health and other community services” sector, the highest proportions reported among OECD countries.

The systems of long-term care services in Sweden and Norway define the “social democratic regime” described by Esping-Andersen (1990). Of the 30 member states of the OECD, only Sweden and Norway spend more than 2 percent of their gross domestic products (GDPs) on long-term care (“Ensuring Quality Long-Term Care,” 2005). Both fund an array of home-based and institutional services mostly provided by public agencies. In Sweden, only 7 percent of services are supplied by nonpublic agencies. In addition to agency-provided services, Sweden furnishes a range of nonfinancial supports to informal caregivers through local governments (Lundsgaard, 2005).

Norway has a similar system of extensive services provided through public agencies, though in most places, in-home services take the form of “freelance” contracts with workers who receive the same pay and pension benefits as do those employed by municipal agencies (Lundsgaard, 2005). In Norway, 6 percent of older people receive institutional services (OECD, 2005a), 70 percent of which are provided in nursing homes and the remainder in residential care. Norway also provides formal home care services to roughly twice the proportion of the older population that does Sweden (Lundsgaard, 2005, p. 34).³

Sweden requires the most education for caregivers and pays the highest salaries among the countries included in a recent international study of “carers” (Johansson and Moss, 2004). The Swedish system is designed to support working women by providing a full array of professional services to older people needing help. Lundsgaard notes the relationship between the provision of formal home care services and the employment of middle-aged women: “There is a tendency for countries with extensive provision of formal home care but only limited financial support for informal care (such as the Scandinavian countries) to have higher employment rates for women aged 50–59 than the United Kingdom, Germany, Austria and Luxembourg, which are countries in this study characterised by limited or

³ Denmark also follows much the same model with high levels of services provided by publicly funded agencies. Denmark has high levels of wages and unionization of direct care workers, as well (Korczyk, 2004).

average provision of formal home care but extensive support for informal care via cash allowances” (2005, pp. 34–35).

Unfortunately, data are sparse on the use of international workers to provide long-term care services in Scandinavian countries. It is considered unethical to collect data on the ethnicity of caregivers in Sweden (Johansson and Moss, 2004). The Scandinavian countries have mutually recognized each other’s nursing credentials and have allowed relatively free migration in their countries for more than 20 years (Buchan, Parkin, and Solchalski, 2003). As a result, the foreign nurses in Norway are almost all from high- and high-middle income countries (mostly other Nordic countries), compared to the great majority of foreign nurses in the United States and the UK, who come from lower- and lower middle-income countries (Buchan and Solchalski, 2004). Norway has begun recruiting nurses from other countries such as the Philippines and Poland, but those numbers were limited to 228 in 2001 and 260 in 2002 (Buchan, Parkin, and Solchalski, 2003).

Rauhut (2004, p. 7) notes that demographics will drive future demand for workers in Sweden, especially workers in “the female-dominated professions in the public sector” to provide services to an aging population. A 2002 report commissioned by the Swedish government recommended improved career opportunities to encourage more immigrant workers to provide long-term care services (Socialstyrelsen, 2005). However, after analyzing potential sources of workers, Rauhut notes that Sweden lacks the historical relations, geographic proximity, and linguistic similarities that have been important dimensions of migration to other developed countries. He concludes pessimistically that “it is unlikely that the theoretically large labour reserves in the countries analysed here have any chance of being realised in practice. It is also a different thing entirely, whether these presumptive migrants even want to move to Sweden. For many of the countries studied, Sweden is not a particularly attractive country to which to move” (2004, p. 7).

C. Italy

With a median age of 42, which is projected to rise to 56 by 2050, Italy trails Japan slightly as the oldest nation in the world (UN Population Division, 2005). Due to low birth rates, Italy already has 30 people age 65 and older for every 100 people 15–64—a ratio that is projected to rise to 50 in 2030 and to 75 in 2050 if fertility rates remain constant (UN Population Division, 2005).

Italy reported 1.5 million foreigners with residence permits in 2003, which comprised only 2.6 percent of the population (OECD, 2005b), but this undoubtedly understates the number of foreigners in the country. Italy has only recently moved from being a net exporter to a net importer of workers, and its immigration policies have not kept up with the growing numbers of foreign workers entering the country. The result is a large percentage of foreigners who are in the country illegally. The government has gone through several waves of immigration reform, each time including some “regularization” of the illegal population (OECD, 2005b; Polverini and Lamura, 2004). Since the mid-1980s, Italy has had five regularizations of illegal immigrants (Bettio et al., 2004); the most recent in 2002 granted legal status to 700,000 workers, nearly half of whom were domestic service workers (Polverini and Lamura, 2004).

Italy's long-term care system has historically depended heavily on family caregiving, but that has been changing in recent years as families grow smaller and more women enter the workforce. In 1983, 14.8 percent of families with an older member received help from family or friends, but that proportion dropped to 11.7 percent by 1998 (Gori, di Maio, and Pozzi, 2004). Nonetheless, an estimated 83 percent of long-term care needs are still met by family and friends (Bettio et al., 2004). Italy continues to have a very low rate of institutional care—only 2.2 percent of the population age 65 and older lived in long-term care institutions in 2000 (Gori, di Maio, and Pozzi, 2004). Regional differences are important, with more formal services, both institutional and home-based, in the more industrial northern regions and stronger traditions of family care in the southern regions (Polverini and Lamura, 2004). In 2001, 8.9 percent of families with a member age 75 or older used private domestic help in the southern part of the country, compared to 6.4 percent of such families in the northern regions (Gori, di Maio, and Pozzi, 2004). On the other hand, 3.2 percent of Italians age 65 and older from the North were in long-term care institutions in 2000, compared to 1.5 percent from the Center, and only 0.9 percent from the South (Gori, di Maio, and Pozzi, 2004).

Italy's system of long-term care financing is divided between health care and social care. Nursing services in the home and in residential settings are funded and administered by the National Health Service and provided through local health authorities. These services are free of charge and are funded through national taxes. Social care, which includes personal and domestic services, is provided through means-tested programs that are regulated and administered by local municipalities and funded through local taxes (Polverini and Lamura, 2004). In addition to agency services, Italy provides cash benefits for persons with serious disabilities through the National Social Security Institute; these are not means tested and are largely unregulated. In 2000, 5.8 percent of Italians over age 65 received such cash benefits (Gori, di Maio, and Pozzi, 2004).

The combination of a strong tradition of care at home by families and friends, the changing roles of women, and the cash benefit financing system has created a huge demand for home care workers to augment family caregiving (Bettio et al., 2004; Polverini and Lamura, 2004). An estimated 80 percent of domestic workers are foreigners, the majority of whom operate in the "gray economy" where taxes are not paid and immigration status is usually not regular (Polverini and Lamura, 2004). In all, roughly half a million foreign workers provide services to older persons through this system (Polverini and Lamura, 2004; see also Bettio et al., 2004 for similar estimates). Though earlier waves of immigrant service workers often came from former Italian colonies in Africa, more recent waves have come primarily from Latin America and Eastern Europe (Bettio et al., 2004).

Informal recruitment networks channel international care workers among neighbors and relatives. Care recipients report high satisfaction, but the international caregivers often report such problems as lack of respect, low wages, and lack of personal time. Caregiving is often a 24/7 job, and international workers sometimes have very little time when they are not on duty (Ungerson, 2004).

Nurse shortages in Italy have led to the rehiring of retired nurses and the use of more foreign workers in institutional settings. Families often hire private, usually foreign, personal assistants to augment care in institutions (Polverini and Lamura, 2004). Some efforts have

been made to bring in more foreign nurses, though these efforts appear to be very limited and local in nature (Barbin, 2004).

D. Austria

Austria's median age of 41 makes it one of the older countries in Europe. The median age is projected to increase to 48 in 2030 and to 50 in 2050. Currently, there are 25 persons age 65 or older for every person 15–64, a ratio projected to increase to 43 in 2030 and to 55 in 2050 (UN Population Division, 2005). One of every eight people in Austria (12.5 percent) is foreign born, higher than the 12.3 percent in the United States, which is generally thought to be more open to immigration (OECD, 2005b). Immigration, both legal and illegal, has increased in recent years (OECD, 2005b), making immigration policy a volatile political issue in Austria. Nearly half of the foreign workers in the country in 2002 were from the former Yugoslav republics of Serbia and Montenegro (35.8 percent), Bosnia (7.6 percent), and Croatia (3.2 percent). Another 16.8 percent of workers were from Turkey, and 11.8 percent were from EU countries (OECD, 2005b).

In 1993, Austria consolidated its social welfare and insurance programs into a single cash benefit for all types of long-term care, institutional and home-based. Reflecting the preference of most people to receive care at home, only 3.6 percent of older Austrians received institutional services in 2000, and another 15 percent received long-term care benefits for care at home (OECD, 2005a). Family accounts for 80 percent of long-term caregiving (OECD, 2005a).

The combination of substantial cash benefits, little regulatory oversight of home care, and a tradition of family caregiving (Kreimer and Schiffbaenkner, 2003) has led to substantial use of international workers. As in Italy, many of these caregivers operate in the gray economy. However, recruitment of international care workers has a pattern unique to Austria. Rather than relying on workers who come from great distances as in Italy, many Austrian caregivers come from neighboring countries such as Hungary and Slovakia. Recruitment agencies find workers who often come on a short-term, rotating basis. Though they are on duty for 24 hours when they are giving care, the short-term rotations result in higher levels of worker satisfaction than in Italy (Ungerson, 2004).

A report sponsored by the Austrian government found fairly high quality in home care and strong consumer satisfaction (Lundsgaard, 2005) but did not specifically look at the quality provided by international workers compared to family caregivers (Nemeth and Pochobradsky, 2004). Ungerson (2004) reports mixed feelings among care recipients regarding foreign workers. Workers often do not speak German well, and there is little long-term continuity of care.

E. United Kingdom

The median age of 39 in the United Kingdom is projected to rise only to 42 in 2030 and to 43 in 2050. As a result, the ratio of persons age 65 and older to those age 15–64 is a relatively low 24. This ratio is projected to increase to 35 in 2030 and to 38 in 2050 (UN Population Division, 2005). Foreign-born persons represent 8.3 percent of the population (OECD, 2005b). The long-term care system in the UK divides responsibility among:

- the National Health Service (NHS), which is responsible for nursing services—even in private nursing homes, and local authorities, which are responsible for care assessment and management;
- the public sector, which pays for much of the care, and the private sector, which provides all of the nursing homes and most of the residential care facilities; and
- family support, which is still the major source of care (OECD, 2005a).

Immigration policy has selectively promoted immigration of skilled workers, especially those providing health and long-term care services. Among all foreign workers in the UK, 14.9 percent work in the “health and other community services” sector (OECD, 2005b). The UK is one of the largest importers of professional health care workers in the world: only 4.9 percent of the British labor force is made up of foreign workers, but nearly a third (29.7 percent) of all NHS doctors in 2003 were first qualified in another country. That trend is intensifying as 57.9 percent of doctors newly registered in 2002 were first qualified in another country (Kelly, Morrell, and Sriskandarajah, 2005). A similar picture describes skilled nurses (see Figure 1 above), where 43.8 percent of newly registered nurses in 2003/04 were first qualified in a country other than the UK (Kelly, Morrell, and Sriskandarajah, 2005).

Recent years have seen a dramatic shift in the numbers and percentages of foreign-trained nurses coming from developing countries, often former colonies of the UK in Asia and Africa. As the number of newly registered nurses who were foreign trained tripled between 1998/99 and 2003/2004, the proportion that came from developed countries in the EU or from Australia, New Zealand, the United States, and Canada declined from 72 percent to 19 percent. Despite restrictions on recruiting from some of the poorest countries (Department of Health, UK, 2004), the number of newly registered nurses from Africa quadrupled during this same period, from 915 to 3,691 (Nursing and Midwifery Council, 2005). Almost half of African nurses came from South Africa.

Disproportionate numbers of foreign nurses work in long-term care settings in the UK for two reasons. As indicated above, the British system of credentialing usually involves a “period of adaptation” during which many foreign nurses work as supervised aides in nursing homes before they are fully certified (Allan and Larsen, 2003). But even beyond the adaptation period, foreign nurses are far more likely than British-educated nurses to work in long-term care. Among foreign-trained nurses, 14 percent work in private nursing homes compared to 5 percent of UK-trained white nurses (Royal College of Nursing, UK, 2002).

International nurses in the UK report a wide array of difficulties in adapting and being accepted in their new working environment (Allan and Larsen, 2003). These nurses had, on average, 14 years of experience before coming to the UK, and they often resented the adaptation period during which they were effectively decredited. In general, international nurses in the NHS were more satisfied with the treatment they received than were those who worked in the private sector, often in privately owned nursing homes. The growing number of international nurses of color was especially likely to report instances of racial discrimination from managers, fellow employees, and clients (Allan and Larsen, 2003).

VII. The Migration of Long-Term Care Workers and Countries of Origin: Brain Drain or Pathway to Development?

The following sections explore factors driving the international long-term care labor markets from the perspective of how they affect the source countries. The demographic factors that are driving a shortage of workers in the more developed countries would seem to be a perfect match for the excess supply of workers in the less developed countries. But the pluses and minuses of health care migration differ enormously among developing countries. Large countries have different issues and priorities from smaller island nations. Some countries promote emigration to receive remittances, while for others, emigration represents the loss of scarce public investments in professional education.

Individual incentives to migrate may be quite different from the interests of the source country as a whole. The individual opportunities for career advancement and higher pay that prompt the migration of nurses and other professionals may be a threat to fragile health care systems. As Alkire and Chen observe, “An individual’s decision to emigrate in search of a better life is rational and legal—yet that same decision may leave whole communities without access to life-saving health care” (2004, p. 2). Moreover, a sound health care system is critical to the economic development of developing countries, as recognized by the United Nations Millennium Development Goals (Sachs, 2005; United Nations, 2005). For some developing countries, the loss of health care workers is a “brain drain” of some of their brightest and most productive workers.

To understand the range of issues related to migration from the perspective of less developed countries, the following sections examine:

- Skill Levels—Brain Drain or Transfer of Skills?
- Economic Impact—Route to Development or Loss of Investment?
- Education—Raising or Lowering Standards?
- Gender—Liberation for Women or a New Dual Labor Market?
- Integrating Foreign Long-Term Care Workers—Professional Enhancement or Discrimination?

A. Skill Levels—Brain Drain or Transfer of Skills?

“In 25 years, Africa will be empty of brains,” warns Dr. Lalla Ben Barka from the UN Economic Commission for Africa (Tebeje, 2005). The idea of brain drain suggests a one-way loss of skills that should be stopped. Indeed, a statement issued by the British Medical Association (2005) and endorsed by the medical and nurses associations of the United States, Canada, South Africa, the UK, and the Commonwealth calls on developed countries to “strive to attain self-sufficiency in their healthcare workforce without generating consequences for other countries.” They specifically call for an end to “reliance on health staff from developing countries (except in the case of countries with government to government agreements).”

But a more complete picture of the movement of skilled professionals from less to more developed countries, including nurses who work in long-term care settings, is much more complex. Whether the movement of professionals is a “drain,” a “strain,” or a “gain” depends on at least three factors: 1) the number of health care workers a country has compared to its health needs; 2) the percentage of the skilled workforce that migrates, and 3) the patterns of migration from and return to less developed countries.

1. Health Care Capacity

The degree to which migration of nurses and other health care professionals is a “brain drain” causing damage to health services in the source countries depends on the human resource capacity of those countries. The migration from developing to developed countries is generally from resource-poor to relatively resource-rich countries. High-income countries have, on average, eight times as many nurses per population as do the low-income countries from which they often recruit nurses. Europe has 10 times as many nurses per population as Africa, and North America has 10 times as many as South America (Buchan and Calman, 2003).

The effects of health care migration on developing countries differ enormously. Alkire and Chen (2004) note that emigration of health care workers is of two types: “policy supported and not policy supported.” Nations that support emigration as a way to earn foreign capital tend to be larger and produce more nurses than their domestic economies can absorb. For example, despite being a major exporter of nurses, the Philippines still has 442 nurses per 100,000 population (WHO, 2005), relatively high for a developing country. India, China, and South Korea also support emigration of large numbers of nurses, but the number of nurses who leave is relatively small compared to the large populations of those countries. Even in these large countries that promote emigration, the loss of nurses can cause local shortages and disruptions in service. The Philippines lost 25,000 nurses in 2003, three times the number of nurse graduates that year (Aiken, 2005), raising questions about the country’s capacity to continue to supply nurses for export at that level.

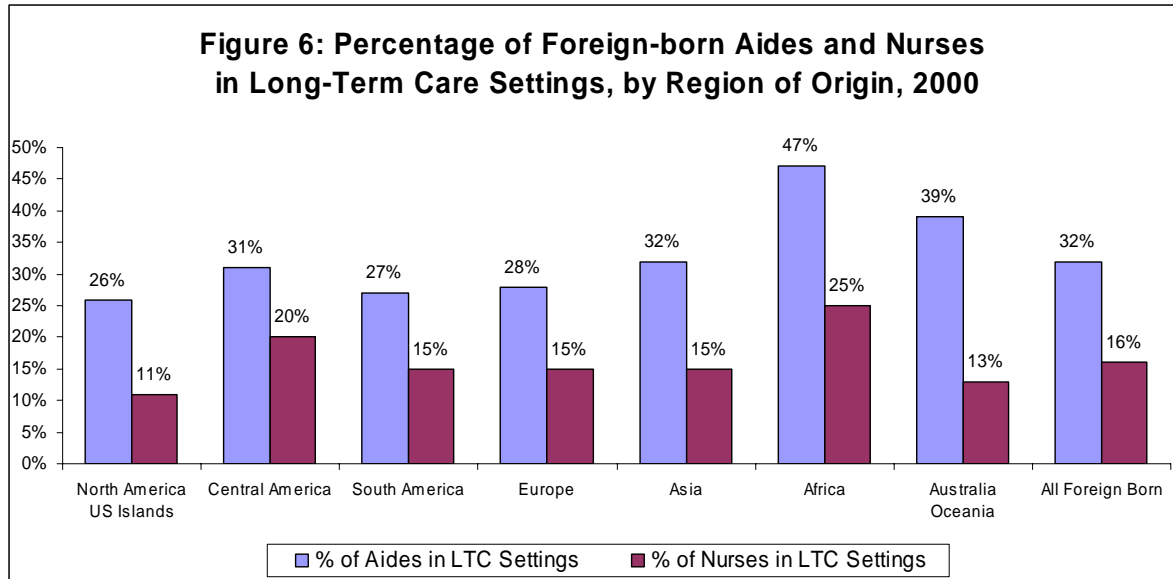
Even though the numbers of migrating health care professionals are much smaller, the impact is more problematic in countries where emigration runs counter to national efforts to build adequate health care systems. The situation is most critical in Africa, which bears 25 percent of the world’s burden of disease but has only 0.6 percent of the world’s health care

professionals to combat those diseases (Gbary, 2005). The sub-Saharan Africa nations of Central African Republic, Chad, Gambia, Liberia, Malawi, Mali, and Uganda have fewer than 20 nurses for every 100,000 population. In comparison, Norway and Finland have more than 1,000 nurses per 100,000 population (Buchan and Calman, 2003).

Active recruiting is not common in Africa, but many health care professionals leave due to poor pay, poor working conditions, and few opportunities for professional advancement. For example, Zimbabwe lost roughly 20 percent of its nurses between 1997 and 2001 (Awases et al., 2004). Between 26 percent and 68 percent of the health care professionals interviewed in six African countries indicated an intention to emigrate (Awases et al., 2004). Even if the absolute numbers are not large, the exodus of even a small number of nurses and other health care professionals from the poorest countries further depletes their limited ability to meet health care needs. High rates of infectious disease, especially HIV/AIDS, tuberculosis, and malaria, are decimating the working-age and younger populations in some areas. Life expectancy is declining in many countries; sub-Saharan Africa experiences 90 percent of the world's malaria deaths and half of the deaths among children under age 5 (UN, 2005).

South Africa has fared better than most of the rest of sub-Saharan Africa. Because of a strong nurse education system, the number of nurses in the country has grown somewhat in recent years (South African Nursing Council, 2005). But the general population is growing faster than the number of nurses, placing additional stresses on the health care system. Salaries are high compared to the rest of sub-Saharan Africa, though they cannot compete with salaries in the UK and other developed countries. South Africa changed from a net importer of health care professionals, mostly from Europe, in the 1980s and early 1990s to a net exporter after the apartheid system was ended in 1994 (Dumont and Meyer, 2004). Currently, 17 percent of health care practitioners from South Africa live abroad (Lowell, et al, 2004)—mostly in the UK, but also in the United States, Australia, Canada, and New Zealand (Dumont and Meyer, 2004). Many of the health care workers now migrating to South Africa come from its poorer neighboring states. The ratio of healthcare professionals to the population remains high relative to the rest of Sub-Saharan Africa, but internal maldistribution of healthcare services and professionals is a legacy of the apartheid era (Awases, 2004; Paradath, et al, 2004).

The exodus of African nurses is especially relevant to long-term care employment in the UK and the United States. Census data show that an increasing percentage of foreign-born nurses comes from Africa; in 2000, 17 percent of foreign-born nurses who work in long-term care settings and who had been in the United States for 10 years or less came from Africa as had 22 percent of the nurse aides (See Tables B6 and B7 in Appendix B below). Moreover, African nurses and nurse aides in the United States are much more likely to work in long-term care settings than are foreign-born nurses and aides from any other region (see Figure 6 below).



Source: U.S. Census data, 2000, AARP PPI analysis

2. *Percentage of Workers Lost*

Sriskandarajah (2005, p. 13) notes that “There are apparently more Malawian doctors working in Britain’s regional city of Manchester than in Malawi itself.” While the exodus of health care and other professionals differs from country to country, legal international migration has increasingly been among the highly educated. Lowell, Findley, and Stewart (2004) estimate that 10 percent of people from developing countries with a tertiary (postsecondary) education lived in North America, Australia, or Western Europe in 2001. The loss of highly skilled workers is most acute in smaller nations and those with limited numbers of people with a tertiary education. As Table 6 shows, Jamaica and Haiti have lost between two-thirds and four-fifths of their highly skilled workers to emigration. On the other hand, even though the percentages of emigrants who have a tertiary education are much higher for China and India, the impact of their emigration is less because they represent a small percentage of the highly skilled workers in those populous countries.

Adams (2003) estimates that 11.7 percent of the Filipino population with tertiary degrees have emigrated to the United States, as have 16.5 percent of those from Mexico with a tertiary education. He notes that “Legal migration to the United States involved the movement of better educated people.” In contrast, he suggests that “low-skilled migration is not very important for most labor-exporting countries,” since it exceeds 10 percent of the low skilled workers in only two countries—Mexico and El Salvador (p. 13).

Some of the highest percentage losses of nurses and other health care professionals occur in smaller island nations, such as the Caribbean (Commonwealth Secretariat, 2005a) and Western Pacific states (WHO, 2004). Every year, 8 percent of the nurses from Jamaica (Lowell, Findley, and Stewart, 2004) and 5 percent of the nurses of Fiji and Samoa (WHO, 2004) leave for larger nations and better pay. Estimates of the annual loss of nurses in the Caribbean run from 460 to 900, creating a vacancy rate of 35 percent in the region (Commonwealth Secretariat, 2005a). A World Health Organization report (2004, p. vii) on

health care migration from Pacific Island nations concludes, “Migration has clear negative outcomes on both the financial and health systems, limiting progress towards ‘Healthy Islands,’ and possibly even resulting in regression in that status.”

Table 6: Skill Levels of Expatriates from Select Source Countries

| | % of Expatriates Who Are Highly Skilled | % of Highly Skilled Workers Who Are Expatriates* |
|---------------------|--|---|
| Nigeria | 55.1% | NA |
| India | 51.9% | 3.1%–3.4% |
| Philippines | 48.1% | NA |
| South Africa | 47.9% | NA |
| Korea | 43.2% | NA |
| China | 39.6% | 2.4%–3.2% |
| Ghana | 34.0% | 31.2%–45.1% |
| Jamaica | 24.0% | 72.6%–81.9% |
| Haiti | 19.8% | 68.0%–78.5% |
| Mexico | 5.6% | NA |

*Highly skilled workers are those with a tertiary education. The OECD reported two sets of percentages for select countries because it compared their data on highly skilled expatriates to two different datasets on educational attainment. Source: OECD, 2005b

3. Patterns of Migration and Return

The Sussex Centre for Migration (2002) describes three patterns of migration, each of which has advantages and disadvantages: simple migration to another country; migration and return to the country of origin; and transnationalism, where migrants maintain strong ties in both countries. The first option, where workers migrate and never return, may maximize both the advantages to the individual and the disadvantages to the country of origin. From the individual’s perspective, migration is often motivated by the desire for higher pay and better professional opportunities (Awases et al., 2004). Returning to the country of origin often means giving up these advantages and becomes harder over time. Research indicates that migrants who leave permanently are less likely to send back remittances than are those who expect to return to families they leave behind (Tiemoko, 2003).

Some observers have recommended policies that encourage a pattern of short-term migration and return as a strategy that could benefit both the host and source countries as well as benefiting the migrating worker (Lowell, 2005; Lowell, Findley, and Stewart, 2004; Black, King, and Litchfield, 2003). Those who return not only send back more remittances, but they bring back both financial capital and human capital in the form of skills gained while they were employed in developed countries (Sussex Centre for Migration Research, 2002). On the downside, returning migrants must often make enormous sacrifices in lost earnings and risk their skills becoming obsolete if they cannot continue to practice the specialized skills more commonly used in developed countries. Moreover, even those who intend to return home find it increasingly difficult to do so over time (Royal College of Nursing, UK, 2002). If they return to their home countries to live, skills are not transferred if the nurses do not practice when they return. George (2005) found that nurses returning from the United States to India often hid the fact that they were nurses because nursing is considered “dirty” work in India.

Some researchers have discussed “transnationalism” as a third option that lies between one-way migration and return. As the Sussex Centre for Migration Research describes it, “Rather than returning or integrating, it seems that many international migrants are more interested in developing ‘transnational’ life styles and perspectives, where they can live ‘between’ or ‘across’ two countries and economies—perhaps two cultures and life styles” (2002, p. 1). By remaining in the host country, the migrating workers keep their skills current and keep generating financial resources, but by remaining in close contact with their country of origin, they provide a bridge for capital and skills that may aid the development of the country of origin. Transnational migrants often spend extended periods in their country of origin providing valuable services and training. George (2005) found strong transnational ties between the Indian community in America and in the home regions of India, which facilitated the transfer of money and the migration of nurses.

B. Economic Impact—Route to Development or Loss of Investment?

Migrating workers from developing countries are generally able to earn far more by leaving their countries of origin, as shown in Table 7. Not surprising, Awases et al. (2004) found that the desire for higher wages and opportunities for promotions were high among the list of motivations for migrating from six African countries.

Table 7: Monthly Wages of Nurses from Source Countries and Host Countries in U.S. Dollars, Purchase Parity Pay Estimates (Most Recent Data from Each Country)

| Source Countries | Monthly Wages | Destination Countries | Monthly Wages |
|-------------------|---------------|-----------------------|---------------|
| South Africa | \$1,486 | United States | \$3,056 |
| Trinidad & Tobago | \$913 | Australia | \$2,832 |
| Côte d’Ivoire | \$530 | Canada | \$2,812 |
| Malawi | \$489 | United Kingdom | \$2,576 |
| Sri Lanka | \$407 | France | \$2,133 |
| Philippines | \$380 | | |
| Ghana | \$206 | | |
| Zambia | \$106 | | |
| Uganda | \$38 | | |

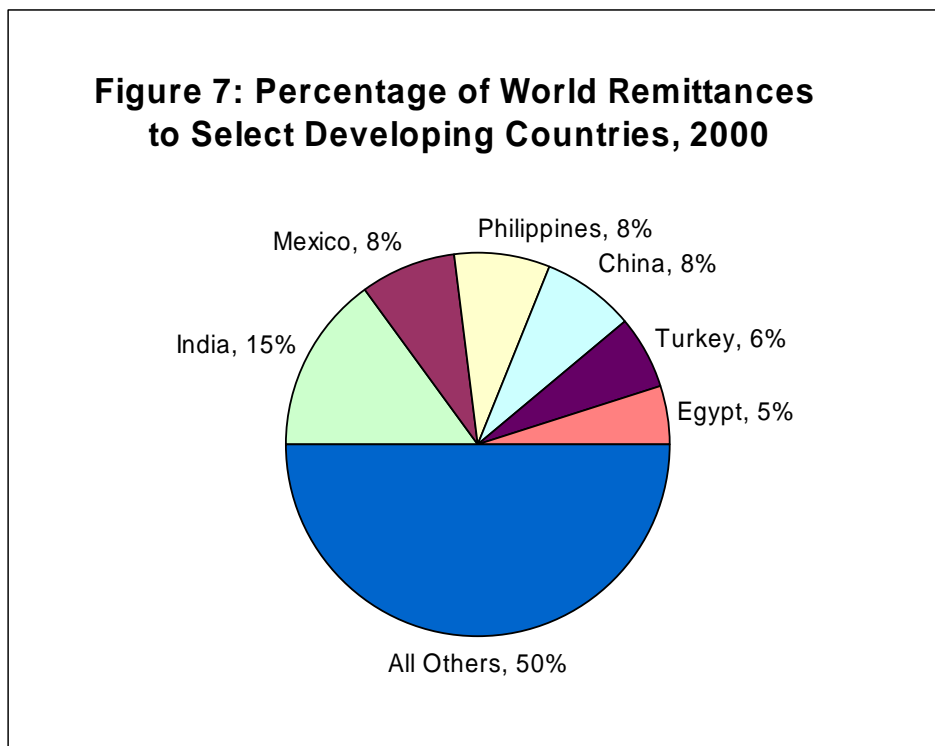
Source: Vujicic et al., 2004

Migrants often remit some incomes to their home countries, especially if they retain strong connections and intend to return home. Official measures of total world remittances were \$93 billion in 2003, greatly exceeding foreign development aid and second only to foreign direct investment in financial capital flows to developing countries (World Bank, 2003).

Remittances, 60 percent of which go to developing countries, are an important source of foreign earnings and economic growth. In countries with high emigration rates of skilled workers, such as Guyana, remittances account for more than 10 percent of the annual GDP (Orozco, 2003). Remittances play such a large role in the economies of many Pacific Island nations that they are sometimes referred to as “MIRAB” countries—for Migration, Remittance, And Bureaucracy (Connell and Brown, 2005). Estimates of income from

remittances are roughly the same as estimates of total GDP in Samoa and Tonga (Connell and Brown, 2004).

Very little research has examined the specific effects of remittances from migrating health and long-term care workers. One exception is a recent study of migrating nurses from Pacific Island states to Australia (Connell and Brown, 2004). This study found that, compared to non-nurse migrating households, the migrating households with nurses were more likely to send remittances, the remittances were higher, and the flow of remittances endured over a longer period. The study concluded that the economic benefits of the remittances from nurses over time outweighed the human capital costs involved in nurse training.



Source: Orozco, 2003

Remittances are not only substantial portions of the GDP in many countries, but they can also be more stable than international aid and less volatile than economic cycles (Sorensen, 2004). Between 1981 and 2000, officially recorded remittances from expatriates grew at a rate more than twice that of GDP growth in the 119 developing countries considered low- or lower middle-income by the World Bank—3.86 percent compared to 1.61 percent (Adams, 2003). Figure 7 shows the percentage of officially recorded world remittances going to the major recipients in the developing countries.

While specific information regarding the remittances of international health and long-term care workers is not available, some countries have set out to encourage the migration of such workers to encourage remittances. The most notable of these countries is the Philippines, which reported more than \$8.5 billion in remittances in 2004 (Bangko Sentral ng Pilipinas, 2005). In the early 1970s, government policy shifted from trying to discourage emigration of

nurses to actively encouraging it, basically turning labor into a commodity export. As President Marcos put it at the time, “we will now encourage the training of nurses because as I repeat, *this is a market* that we should take advantage of. Instead of stopping nurses from going abroad *why don’t we produce more nurses? If they want one thousand nurses we produce a thousand more*” (quoted in Choy, 2003, pp. 115–116, her emphasis).”

The net impact of immigration on development in less developed countries is not entirely clear. Remittances are an important source of revenue, but they also come at the loss of workers who are better educated on average and at the peak of their productive years. Remittances to India equaled 2.1 percent of GDP in 2001, while the fiscal loss due to emigration was estimated at 0.6 percent of GDP. Nevertheless, the net effect may not be as positive in all countries (Holzmann and Muenz, 2004). Families receiving remittances are less likely to be in poverty and more likely to send their children to school (UN Department of Social and Economic Affairs, 2004). However, remittances that support the subsistence of family remaining behind may not support investments that contribute to economic growth (Sorenson, 2004). For example, Connell and Brown note that, in Pacific Island countries, “Remittances tend to go to senior family members who use them in traditional ways instead of for structural changes such as land tenure reform” (2005, p. 11).

Beyond remittances, the UN Millennium Development Goals have recognized the critical importance of basic health in achieving economic development (United Nations, 2005; see also Sachs, 2005), especially in the world’s poorest countries. The UN’s most recent progress report (United Nations, 2005) notes that sub-Saharan Africa lags far behind the rest of the world in meeting those social and economic development goals. The British Medical Association (2005) estimates that sub-Saharan Africa would need a million more health care workers to meet those goals by 2015.

C. Education—Raising or Lowering Standards?

In most developing countries, the cost of educating nurses and other health care professionals is paid with public resources. When these professionals emigrate, the country of origin loses not only their skills and services, it loses its educational investment as well. Some of the poorest countries lose the most, since they invest disproportionately in educating health care professionals to meet their needs. Gbary (2005) estimates that African nations are “subsidizing” more developed nations with \$500 million in training costs each year. Data from the Pan-American Health Organization (cited by Commonwealth Secretariat, 2005a) indicate that Caribbean nations lose \$5,300 per nurse who migrates.

A major exception to public funding is the Philippines, where nurse education is largely privately funded. The number of Filipino nursing schools exploded from 63 in the 1970s to 198 in 1998 in response to the international demand for Filipino nurses (Bach, 2003). Families often save to educate their female members as nurses with the goal of having them migrate to get a return on the investment (Choy, 2003; see George, 2005, for a similar discussion of India).

The impact of migration on the quality of nurse education has undoubtedly been mixed. In some cases, nurses are taught to international (especially U.S.) standards so that graduating

nursing students can pass licensing exams in other countries. To the extent that these standards are more demanding, the quality of education may be improved. Quality may be also improved due to staffing nursing schools with nurses returning from more developed countries. But nursing instructors are also lured away to other countries. For example, India is losing large numbers of nursing instructors, and the losses are particularly acute in the southern part of the country where much of the migration is taking place. In addition, public institutions have lost faculty to private schools that have sprung up to meet the demand (Falaknaaz-Mumbai, 2003).

The proliferation of nursing schools has undoubtedly opened up opportunities for an education and professional career for many women. But the quality of many Filipino nursing schools is often uneven at best; the Commission on Higher Education found that 103 of 170 existing nursing programs were of poor quality (Aiken, 2005). Quality problems have also emerged in some areas of India, which one informant interviewed by George (2005, p. 53) attributed to the lucrative business of training nurses for export: “Nursing has become a business... If they build a hospital, its main source of income is the nursing school they attach to it.”

D. Gender—Liberation for Women or a New Dual Labor Market?

Nurse migration is part of a global trend toward the “feminization of migration.” Shifting demands of the service-driven economies in the more developed countries are increasing the demand for workers in what has traditionally been seen as women’s work (Rauhut, 2004). As a result, in 2000, women represented 51 percent of migrants in more developed countries, but only 45 percent of migrants in less developed countries (UN Department of Social and Economic Affairs, 2004). Data on migrants to the United States indicate that 59 percent of the foreign-born population from the Philippines in 2003 were women, as were 58 percent of those from Korea and 55 percent of those from Jamaica (OECD, 2005b).

Nursing continues to provide professional opportunities to women where few others exist in many less developed countries. Increasingly, these women are pursuing careers independently, rather than following husbands in their careers. Choy notes that the Filipino nurse’s cap was viewed as a “passport” to job opportunities and personal liberation: “The Filipino nurse’s cap became the material expression of Filipino women’s modernity, a symbol of their liberation that contrasted with the oppressive imagery of Japanese women’s ‘dainty kimono,’ Indian women’s ‘mysterious veils,’ and Chinese women’s ‘mannish trouser legs’” (2003, p. 36).

This liberation can be more complicated for married women than for the single women who predominate among Filipino migrants. George (2005) describes the often difficult renegotiation of traditional gender roles involved when men found themselves in a dependent position after they followed their wives who moved from India to the United States to work as nurses. A similar situation describes migrating nurses from Pacific Island nations to Australia, where 50 percent of the nurses’ spouses were unskilled laborers, and only 8.4 percent held jobs of equivalent status (Connell and Brown, 2004).

Personal liberation is certainly not the only experience of migrating women. Evidence of exploitation, discrimination, and criminal trafficking are also distressingly common. The worst stories often come from Saudi Arabia and the Gulf States, where many women from the Philippines, India, Sri Lanka, and other countries migrate to provide nursing and domestic services. These workers frequently report physical and sexual abuse (Waldman, 2005). One of the more notorious U.S. cases was uncovered by investigators in the mid-1990s: 500 nurses were brought illegally from the Philippines to work in nursing homes in Texas and Oklahoma, some as aides working for as little as \$5 an hour (Choy, 2003; Stewart, 2005). In addition to the illegal exploitation of the migrants, the influx of migrants affected the local markets for long-term care workers—depressing the prevailing wage for RNs in Lubbock from \$14 to \$11 per hour (Stewart, 2005).

E. Integrating Foreign Long-Term Care Workers—Professional Enhancement or Discrimination?

Less dramatic, but more common than illegal trafficking and exploitation, is the discrimination and isolation many migrating workers experience. Integrating migrating nurses and aides can be a major challenge for employers and workers. Nurses report discrimination based on race or foreign status from clients, fellow professionals, and administrators (George, 2005; see also Choy, 2003). Despite these reports, recent surveys of foreign-educated registered and practical nurses in the United States found that they experience fairly high levels of respect, as shown in Table 8.

Table 8: Percentage of Foreign Nurse Graduates Who Felt They Received the Same Level of Respect as or More Respect than U.S.-Born Nurses

| Respect from | RNs | LPNs |
|----------------------------------|------------|-------------|
| Other health care workers | 88% | 87% |
| Other nurses | 87% | 88% |
| Physicians | 85% | 85% |
| Families of patients | 85% | 88% |
| Patients | 83% | 89% |

Sources: Commission on Graduates of Foreign Nursing Schools (2002, 2005)

Some of the seeming discrepancy between reports of discrimination and the survey results in Table 8 may be due to the research methods used. Qualitative methods that probe experiences more thoroughly than survey questions may be more effective in eliciting information about experiences of discrimination. For example, the ethnographic approach George (2005) used may have given her access to a more complete and honest picture of workplace discrimination. Similarly, focus group research on internationally recruited nurses in the UK found a mixture of experiences that sometimes included discrimination (Allan and Larsen, 2003).

Some of the differences in findings regarding discrimination may also reflect different experiences in different types of settings. Generally, international nurses working for the UK's National Health Service reported more positive experiences than did those working in the private sector—where a disproportionate number of international nurses work in nursing homes (Allan and Larsen, 2003). George (2005) notes that feelings of isolation and

discrimination may occur more commonly when there are no other staff from the worker's home country, even when other foreign-born workers are present.

Finally, some of the differences in findings regarding discrimination and respect may reflect genuinely ambivalent experiences and feelings rooted in having two frames of reference—one comparing experiences to other workers in the United States and one comparing experiences in the country of origin. George (2005) reports that, despite sometimes experiencing discrimination, Indian nurses generally experienced higher professional prestige in the United States than they had in India. The greater responsibility associated with American nurse practices and the availability of better technology contributed to a sense of “greater professional gratification” among these nurses. She concludes (p. 67) that, “Despite structural barriers posed by the difficulty of incorporation and by racial discrimination, immigrant nurses are able to find new professional self-worth through their work experiences.”

VIII. How Is the Quality of Long-Term Care Affected by the Use of International Workers?

Of particular concern to policy decision makers is immigration's effect on the quality of long-term care services. Most developed countries experience quality problems in long-term care services (OECD, 2005a). The degree to which international workers improve quality or create problems is a very complicated question—involving multiple policy objectives and definitions of “quality.” The following sections look at the limited evidence that speaks to quality outcomes and international workers and raise some policy issues that must be addressed.

A. Is Immigration the Best Way to Address Worker Shortages?

When the OECD (2005a) surveyed its member countries about long-term care issues, “staff shortages and staff qualifications” was by far the most frequently mentioned concern; indeed, it was the only response offered by all of the respondents. Abundant research has documented the relationship between staffing levels and quality outcomes in long-term care services (Institute of Medicine, 2001). Shortages affect the quality of long-term care services directly through the inability to provide adequate service. But equally important are the indirect effects of shortages reflected in overworked staff, declining morale, and high staff burnout and turnover. To the extent that international workers relieve the stresses of staffing shortages, they can be part of a strategy to improve the quality of care (Hoppe, 2005).

One way to relieve the stress would be to train more health care workers domestically (Aiken, 2005). The medical and nurses associations of the United States, Canada, South Africa, the UK, and the Commonwealth called on developed countries to achieve self-sufficiency in their health care workforces rather than rely on developing countries to supply needed workers (British Medical Association, 2005). Whether such self-sufficiency is possible or desirable is an open question. The increasing numbers of older people and declining numbers of people of working age in developed countries may make self-sufficiency increasingly difficult for some countries. Even with increased domestic training,

migration of international long-term care workers is likely to continue because of higher salaries and better working conditions.

Destination countries have widely differing traditions, laws, and policy objectives related to immigration. To deal with the demographic and economic realities shaping the world, they will need to deal with the following questions related to human resource development and immigration policy:

- Can developed nations realistically develop strategies to become self-sufficient in health care workers?
- Can countries that have largely excluded immigrants in the past continue such policies in the face of aging populations?
- Should immigration laws exclude skilled workers from countries with health care worker shortages?
- Should temporary visas be used to promote return migration, or should permanent visas be used to improve the integration of migrating workers?
- How can bilateral and multilateral agreements dealing with the immigration of specific types of health and long-term care workers best promote the mutual benefit of source and destination countries?

B. How Can Public Agencies Be Sure that International Workers Are Qualified?

If developed countries continue to rely on international workers to provide long-term care services, then assuring that the workers are able to do the work will be a major concern. By many measures of quality, international workers fare reasonably well in the comparison. For example, 40 percent of newly licensed, foreign-educated RNs in the United States had baccalaureate degrees, compared to 29 percent of a nationally representative survey of all RNs (Commission on Graduates of Foreign Nursing Schools, 2002). Half or more of foreign-educated RNs and licensed practical nurses (LPNs) have more than five years' experience when they are licensed in the United States, giving them more experience than newly licensed nurses educated in the United States (see Table B29 in Appendix B). Perhaps because of their education and experience, newly licensed, foreign-educated nurses are less likely than their U.S.-educated counterparts to report having been involved in errors, especially those related to medication management (Smith and Crawford, 2004; see Table B30 in Appendix B below).

However, the higher failure rate of international candidates taking the U.S. licensing examination every year raises questions about the education these candidates received. As the globalization of the economy expands, professional credentialing is becoming a part of international trade agreements. More standardization of professional credentials can either raise the standards of countries that have inadequate standards or fail to recognize the differing needs of different countries and types of care. Some issues that will require consideration:

- To what degree should bilateral and multinational agreements provide for the mutual recognition of health care professional credentials?
- Will the testing procedures of the United States become the de facto international standards for professional credentials because they are the most commonly used? What impact would such a de facto standard have?
- Are testing procedures for health care professionals culturally biased?
- Would the effective imposition of standards from developed countries fail to address the needs in the countries of origin (e.g., less emphasis on the infectious diseases more common in less developed countries)?

C. How Can Developed Countries Meet the Demand for Unskilled Workers?

Much of the research and policy attention regarding the international migration of health and long-term care workers and credentialing has focused on skilled nurses. But most long-term care work is done by unlicensed, lower-skill workers. Responding to consumer demand for more choice and control, many developed countries are moving toward greater use of cash benefits (OECD, 2005a), which are likely to increase the demand for low-wage, low-skill personal assistants. In some developed countries, these jobs are often filled by international workers, many of whom have migrated illegally.

Little research speaks to the impact of these trends on quality. The OECD notes that “objective evidence on the quality of home care is in many countries even more limited than in the case of nursing-home care. Most of the research in this area measures *satisfaction* and *unmet need*, and not quality of care in a strict sense” (2005a, p. 70). A survey of recipients of Austria’s cash benefit program found that 77 percent reported receiving good care, 20 percent reported receiving generally good care with relatively minor needs for change, and 3 percent reported needing more significant improvements (Nemeth and Pochobradsky, 2004). Research on foreign workers’ specific impact on quality is especially lacking. A limited survey in central Italy found that 94 percent of privately hired personal assistants had no care work qualification at all. Of foreign home care workers employed by Italian nonprofit agencies, 27 percent had previous experience in providing care, and 52 percent had been offered training opportunities in caregiving (Polverini and Lamura, 2004).

Despite the scarcity of evidence related to quality outcomes, the OECD notes that “The level of satisfaction expressed by people who are cared for at home is relatively high compared to the much higher number of complaints regarding care deficits in institutions” (2005a, p. 70). Much of this satisfaction is undoubtedly related to the fact that family members provide a high proportion of such care. But some observers believe that many immigrants come from cultures that honor elders, and that immigrant caregivers make up with caring behavior what they may lack in technical and language skills. As Dr. Luisa Bartorelli, director of the geriatric department at Sant’Eugenio Hospital, put it, “We’re finding that immigrants are proving to be very good carers. They have the right attitude, because they often come from countries where the older generation has a role in society and is respected much more than here” (Smith, 2005).

The use of immigrant workers is a growing factor in allowing people to stay at home, raising some important policy issues:

- Should immigration policies regarding unskilled workers be liberalized to meet long-term care workforce shortages?
- Can increased training improve the quality of services international nurse aides and home care workers provide?
- Should cash benefit programs restrict the types of workers who provide care and set minimum qualifications for such care?

D. How Do Cultural and Linguistic Differences Affect Quality of Care?

Long-term care involves some of the most intimate of services over an extended period. Good communication and a supportive relationship between the caregiver and the person with a disability are critical to good care. Cultural preferences regarding care can be obstacles to successful relations if the caregiver does not understand and address those preferences (Office of Minority Health, 2001). Of course, cultural preferences can easily shade into prejudice against workers from a different cultural background, which can also impede the effectiveness of care.

The most obvious cultural issues with respect to long-term care workers relate to language barriers. Language skills are particularly problematic among unskilled workers. In a study of foreign home care workers in Italy, 36 percent of family-hired personal assistants and 16 percent of agency-hired workers had no knowledge of Italian or just sufficient understanding—and more than half of each had insufficient understanding of written Italian (Polverini and Lamura, 2004). In the United States, 11.8 percent of nurse aides in long-term care settings reported in the 2000 census that they could not speak English or that they could not speak it well (see Table B26 in Appendix B below). Among skilled nurses, language differences can be an issue in communicating between caregivers and clients and is a major factor in success or failure in the credentialing process (George, 2005). Even when an international nurse is fluent in the language of the host country, different dialects and accents can be an obstacle to communication and can stigmatize the nurse (Allan and Larsen, 2003).

A more diverse workforce can have advantages in meeting the needs of an aging population that is becoming more culturally diverse in some developed countries, most notably those countries with histories of high levels of immigration. A survey by the National Council of State Boards of Nursing (Smith and Crawford, 2004) found that newly licensed foreign educated nurses in the United States were somewhat more likely to have problems understanding English-speaking clients or staff than were newly licensed nurses educated in the United States, but they were far less likely to have such problems when dealing with non-English-speaking clients or staff (see Table B28 in Appendix B).

Understanding the culture of caregiving can also be an issue. The transition period immediately after arrival can be critical in the successful integration of a new international worker (Hoppe, 2005; Allan and Larsen, 2003). Some international nurses come from

cultures of caregiving where nurses do not question physician orders, so learning to be assertive with doctors and other professional staff can be a major challenge (George, 2005; Hoppe, 2005). On the other hand, because they generally start with more experience than newly registered, native-born nurses, foreign-born nurses come with some advantages in the transition to caregiving. For example, foreign-trained nurses were less likely to indicate problems reading and understanding physicians' orders than were new nurses educated in the United States (Smith and Crawford, 2004; see Table B28 in Appendix B).

The U.S. Office of Minority Affairs (2001) issued standards for "culturally and linguistically appropriate services in health care." These standards have given more visibility to the need to match the cultural understandings of care between caregivers and clients, but they also raise important policy and practice-related questions:

- Are voluntary or mandatory standards more effective in promoting culturally competent care?
- How can the management of long-term care organizations smooth the transition and integration of international workers?
- How can international workers be used more effectively to address the diversity of the aging populations in developed countries?
- How can public agencies assure the cultural competence of home care services?

E. Do Migrants Depress Wages and Undermine Working Conditions?

From the perspective of unions and professional associations representing nurses, increased use of international workers reinforces the dual labor market conditions they are trying to eradicate (Van Eyck, 2004). From this perspective, employing foreign workers undermines efforts to improve wages and working conditions for nurses and aides. As the American Nurses Association (2005) put it in its message to Congress, "Over-reliance on foreign-educated nurses serves only to postpone efforts required to address the needs of the U.S. nursing workforce. Foreign-educated nurses brought into the United States tend to be placed in jobs with unacceptable working conditions with the expectation that these nurses, as temporary residents and foreigners, would not be in a position to complain."

The counterargument is that immigrating workers are only filling jobs native-born workers do not want and are unlikely to take even if working conditions improve. In the United States, foreign-born nurses and aides in long-term care settings are more than twice as likely as their native-born counterparts to work in central cities (see Tables B19 and B20 in Appendix B; see also George, 2005). Indeed, more than a quarter of nurses and aides in long-term care settings in central cities are foreign born (see Table B21 in Appendix B). In countries that make extensive use of foreign live-in caregivers, native-born workers are unlikely to be attracted to the low pay and constant duty required of live-in workers.

Wages are generally higher for foreign-born workers in U.S. long-term care settings than they are for native-born workers. The median income for foreign-born aides was \$17,000 in

2000, compared to \$13,800 for native-born aides; for foreign-born nurses, the median income was \$34,000, compared to \$28,000 for native-born nurses in long-term care settings (based on a 40-hour week; see Table B31 in Appendix B). These wage differences reflect higher levels of education, experience, and willingness to work in central city locations that pay higher wages (Arends-Kuenning and McNamara, 2004; George, 2005). Supporters of increased migration cite such data in arguing that foreign workers are not having a negative effect on wages and working conditions but are filling critical vacancies for services that otherwise would go unfilled.

However, some cautionary notes are in order. Arends-Kuenning and McNamara (2004) found that foreign-born workers in the United States actually earn lower wages than do native-born workers during their first few years of employment when other factors are controlled. They speculate that foreign-born workers may be more committed to their careers, so they earn more in the long run than native-born workers. Also, workers earning lower wages may be more likely to return to their countries of origin. Though Arends-Kuenning and McNamara did not raise the issue, the difference between short and long term may also be due to workers shifting from low-wage, entry-level jobs, often in long-term care, after a few years of experience. Obviously, the experience is likely to be different in other countries and for low-skill workers in the gray economy. Clearly, more research should address questions related to the effects of international workers on the wages and working conditions of long-term care workers.

- To what extent would higher wages and better working conditions attract native-born workers to long-term care settings?
- To what extent does the use of foreign workers alleviate shortages that undermine worker morale?
- To what extent are foreign long-term workers, especially home care workers operating in the gray economy, exploited with long hours, low wages, and abusive behavior?

F. What Responsibility Do Developed Countries Have for the Impact on Source Countries?

Importing large numbers of health care workers, especially skilled nurses, to work in long-term care settings can have negative consequences for the nurses' countries of origin. Various suggestions have been made to deal with those consequences or to compensate for them. The statement of the British Medical Association (2005) calls on developed countries to "assist developing countries to expand their capacity to train and retain physicians and nurses to enable them to become self-sufficient." If more developed countries are going to continue to recruit workers from less developed countries, then developing teaching programs in less developed countries and compensating for the investments in training health care professionals made by those countries are issues to consider (Commonwealth Secretariat, 2005a). Building the health care delivery and professional education systems in the poorest countries will likely require the commitment of human and financial resources from more developed countries (Alkire and Chen, 2004; Sachs, 2005).

As the number of migrating health care workers has increased, so has the call for closer monitoring of recruitment practices. From a recruiting agency's perspective, concentrating recruitment in a specific country and a specific locality in that country may be efficient, but it may drain the health care workers from that locality. Ethical considerations also arise about recruiting from countries with critical health care needs and a shortage of workers—such as the AIDS crisis in sub-Saharan Africa—when a large percentage of the health care workers emigrate. Finally, issues have arisen regarding the degree to which recruiters have fulfilled their promises to migrating workers. All of these considerations raise important policy questions:

- How effective are multinational and bilateral agreements related to the recruitment of health care workers?
- How effective are ethical standards for recruiters recommended by professional associations?
- Should destination countries impose regulations on recruiters? What sanctions and monitoring should those regulatory systems include?
- What are the long-term effects on source countries of losing health care workers? What is the responsibility of the countries receiving these workers in addressing the health care problems of the countries that are losing these workers?

IX. Conclusions

Addressing the issues raised by migration of health and long-term care workers is made exceedingly complex by a number of factors:

- *Different migration patterns:* In some developed countries, such as Norway, most of the foreign-born health and long-term care workers come from other developed countries. The UK, on the other hand, has seen a dramatic shift from workers from EU countries to workers from developing countries in Asia and Africa. Still another pattern is from developing country to developing country, as in migration to South Africa from neighboring states such as Lesotho. In developing countries like India and South Africa, internal migration from poor rural areas to urban areas can be as important as international migration in allocating scarce health-related resources (Bach, 2003).
- *Different needs for workers in developed countries:* Different long-term care financing systems, different cultural preferences for care, different immigration policies, different demographic trends, and different workforce dynamics create very diverse issues among developed countries that demand a range of solutions. Countries with low immigration rates may have to open their doors to more foreign workers, which may present difficult transitions toward more multicultural and multiracial societies.

- *Different situations in the developing countries that are the source of long-term care workers:* Small island countries losing large percentages of their health care workers face very different issues from large countries that intentionally train workers for export. The poorest countries, especially in Africa, face a serious health care crisis that is worsened by the loss of already scarce health care professionals. Developing countries are also beginning to face larger numbers of older people needing long-term care services. Different circumstances call for different types of engagement between source and destination countries to maximize the benefits to both.
- *Different skill levels:* Much policy attention regarding the migration of health and long-term care workers has focused on highly skilled doctors and nurses. But most long-term care is done by unskilled workers who have great difficulty immigrating legally to most developed countries. As the demand for unskilled workers increases, so will the need to address unskilled, often illegal, immigration. The lack of training and vulnerability to exploitation among unskilled and illegal workers will also demand more attention.
- *Different policy areas and objectives:* The increased use of international workers in long-term care involves policy issues related to health and long-term care, immigration, labor standards, and development assistance. Most countries have little or no coordination among agencies and policy decisions in these areas. Shifts in long-term care policy may create demands for unskilled workers that immigration policies do not accommodate. Similarly, international development assistance to the poorest countries may not be effective without dealing with the migration of skilled professionals. Coordinating policies within developed countries may be as complex as coordinating international efforts to address health and long-term care issues.

In short, the widely differing circumstances of both source and destination countries, and the range of public and private interests involved will defy simplistic solutions to the issues raised by the migration of health and long-term care workers. Addressing one set of issues may create unintended consequences for a different policy area and will require increasing attention to how the various relevant areas of policy interact. Moreover, addressing the need for health and long-term care workers in the more developed countries can only be done ethically when also addressing issues related to the economic development and health-related service needs of less developed countries.

Meeting the long-term care needs of the growing older populations in more developed nations and the economic development needs of less developed nations requires more engagement across international boundaries. The quality of the long-term care older persons receive in the more developed countries may increasingly depend on the quality of the engagement with the less developed countries that are likely to supply more of the workers in the future. The array of policy options, programs, and international arrangements used will have to be flexible and tailored to fit the very different needs of each country. With respect to larger developing countries with policies that promote the emigration of workers, more developed countries may pursue policies that emphasize ethical recruiting and help develop the education systems that are training large numbers of their workers. With respect to smaller countries, policies that promote the return of health care workers may be most

effective. The catastrophic health care situation in much of sub-Saharan Africa will require a more comprehensive approach to promote economic development and the stabilization of health care systems under extreme stress.

Much more research is needed in developed countries to inform policy decisions regarding long-term care delivery, integration of foreign workers, consequences of different forms of public and private financing, and consequences of various approaches to immigration policy. Research in developing countries might look at successful strategies for developing health and long-term care systems, including training and retention of workers and reintegration of workers who have spent some time abroad back into their native countries.

Finally, policies and programs that address needs at the national level cannot ignore the individual needs and aspirations both of those who need long-term care and those who would provide that care. Long-term care and immigration policies cannot ignore the aspirations of individuals with disabilities who want high-quality services that support their dignity and independence. And those programs and policies are unlikely to work unless they recognize and address the aspirations of individuals who are migrating to improve their lives and the lives of their families. Meeting these individual aspirations and national priorities in a period of global change is one of the major policy challenges of aging societies.

REFERENCES

- AARP Global Aging Program. 2003. *AARP International Forum on Long-Term Care Proceedings*. Washington, DC: AARP.
- Adams, Richard H., Jr. 2003. "International Migration, Remittances, and the Brain Drain: A Study of 24 Labor Exporting Countries." *World Bank Policy Research Working Paper 3069*. Washington, DC: World Bank.
- Aiken, Linda. 2005. Presentation to the *Health in Foreign Policy* Forum sponsored by AcademyHealth. Available at <http://www.academyhealth.org/nhpc/foreignpolicy/index.htm>
- Aiken, Linda H., James Buchan, Julie Sochalski, Barbara Nichols, and Mary Powell. 2004. "Trends in International Nurse Migration." *Health Affairs* 23 (3): 69–77.
- Aiken, Linda H., Sean P. Clarke, Douglas M. Sloane, Julie A. Sochalski, Reinhard Busse, Heather Clark, Phyllis Giovannetti, Jennifer Hunt, Anne Marie Rafferty, and Judith Shamian. 2001. "Nurses' Reports on Hospital Care in Five Countries" *Health Affairs* (May/June): 43–53.
- Alkire, Sabina, and Lincoln Chen. 2004. "Medical Exceptionalism in International Migration: Should Doctors and Nurses Be Treated Differently?" The Global Equity Initiative, Cambridge, MA: Harvard University Asia Center.
- Allan, Helen, and John Aggergaard Larsen. 2003. *"We Need Respect": Experiences of Internationally Recruited Nurses in the UK*. London: Royal College of Nursing.
- American Nurses Association. 2005. "Immigration and the Nursing Workforce." Available at <http://nursingworld.org/gova/federal/legis/107/immigr.htm>
- Arends-Kuenning, Mary, and Paul E. McNamara. 2004. "The Balance of Care: Trends in the Wages and Employment of Immigrant Nurses in the U.S. between 1990 and 2000." Presented at a conference on Gender and Transnational Care Work, October 21.
- Awases, Magda, Akpa R. Gbary, Jennifer Nyoni, and Rufaro Chutora. 2004. *Migration of Health Professionals in Six Countries: A Synthesis Report*. Brazzaville, Republic of the Congo: World Health Organization, Regional Office for Africa.
- Bach, Stephen. 2003. *International Migration of Health Workers: Labour and Social Issues*. Geneva: International Labour Organisation.
- Bangko Sentral ng Pilipinas. 2005. "Overseas Filipino Workers' Remittances by Country and Type of Worker." Available at <http://www.bsp.gov.ph/Statistics/sefi/ofw.htm>

- Barbin, Jean-Gabriel. 2004. "Recruitment of Nurse in Romania by the Friuli-Venezia-Giulia Region of Italy." In *Migration, for Employment: Bilateral Agreements at a Crossroads*. Paris: OECD.
- Bettio, Francesca, Annamaria Simonazzi, Giovanni Solinas, and Paola Villa. 2004. "Female Migrants in the Italian Elderly Care System." Unpublished paper presented at the 25th Conference of the International Working Party on Labour Market Segmentation, Intergenerational Issues, the Welfare State and the Labour Market, Brisbane, Australia.
- Black, Richard, Russell King, and Julie Lichtfield. 2003. *Transnational Migration, Return and Development in West Africa*. Sussex, UK: Sussex Centre for Migration Research.
- Brasor, Philip. 2004. "Light Remains Green for Filipinos in Japan—Well Kind Of." *Japan Times*, November 28.
- British Medical Association. 2005. "The Healthcare Skills Drain—A Call to Action." Statement of principles from a conference on global health workforce needs, April 14.
- Brush, Barbara L., Julie Solchalski, and Anne M. Berger. 2004. "Importing Care: Recruiting Foreign Nurses to U.S. Health Care Facilities." *Health Affairs* 23 (3): 78–87.
- Bryant, Rosemary. 2005. *Regulation, Roles and Competency Development*. Geneva: International Council of Nurses.
- Buchan, James, Mireille Kingma, F. Marilyn Lorenzo. 2005. *International Migration of Nurses: Trends and Policy Implications*. Geneva: International Council of Nurses.
- Buchan, James, and Julie Solchalski. 2004. "The Migration of Nurses: Trends and Policies." *Bulletin of the World Health Organization* 82: 587–594.
- Buchan, James, Tina Parkin, and Julie Solchalski. 2003. *International Nurse Migration: Trends and Policy Implications*. Geneva: World Health Organization.
- Buerhaus, Peter I., Douglas O. Staiger, and David I. Auerbach. 2004. "New Signs of a Strengthening U.S. Nurse Labor Market?" *Health Affairs*, Web exclusive (November 17): W4-526–W4-533.
- Campbell, John C. 2002. "How Policies Differ: Long-Term-Care Insurance in Japan and Germany. In Harald Conrad and Ralph Lutzeler (eds.), *Aging and Social Policy—A German-Japanese Comparison*. Munich: Iudicium
- Chikanda, Abel. 2004. "Skilled Health Professional Migration and Its Impact on Zimbabwe." *Centre on Migration, Policy and Society Working Paper No. 4*. Oxford, UK: University of Oxford.

- Choy, Catherine Ceniza. 2003. *Empire of Care: Nursing and Migration in Filipino American History*. Durham, NC: Duke University Press.
- Comas-Herrera, Adelina, Raphael Wittenberg, and Linda Pickard. 2003. "Long-Term Care for Older People in the UK. In Adelina Comas-Herrera, Joan Costa-Font, Cristiano Gori, Alessandra di Maio, Concepcio Patxot, Linda Pickard, Alessandro Pozzi, Heinz Rothgang, and Raphael Wittenberg (eds.), *European Study of Long-Term Care Expenditure*. Brussels: European Commission.
- Commission on Graduates of Foreign Nursing Schools (CGFNS). 2002. *Characteristics of Foreign Nurse Graduates in the United States Workforce, 2000–2001*. Philadelphia: CGFNS.
- Commission on Graduates of Foreign Nursing Schools (CGFNS). 2005. *Characteristics of International Practical Nurses in the United States Workforce, 2003–2004*. Philadelphia: CGFNS.
- Commonwealth Secretariat. 2005a. *A Managed Temporary Movement Programme for Teachers and Nurses: Preliminary Assessment of Policy Options for the Managed Temporary Movement of Caribbean Teachers and Nurses to Canada, the United Kingdom, and the United States*. Ottawa, Canada: Carleton University.
- Commonwealth Secretariat. 2005b. "Framework of Action for a Programme of Temporary Movement of Nurses." Barbados.
- Connell, John, and Richard P. C. Brown. 2004. "The Remittances of Migrant Tongan and Samoan Nurses from Australia." *Human Resources for Health* 2 (2).
- Connell, John, and Richard P. C. Brown. 2005. *Remittances in the Pacific: An Overview*. Manila: Asian Development Bank.
- Crawford, Lynda, Thomas R. O'Neill, Michelle Reynolds, and Esther White. 2005. *2003 Nurse Licensee Volume and NCLEX® Examination Statistics*. Chicago: National Council of State Boards of Nursing (NCSBN).
- Department of Health, UK. 2004. *Code of Practice for the International Recruitment of Healthcare Professionals*. London: Department of Health.
- Diallo, Khassoum. 2004. "Data on the Migration of Health-Care Workers: Sources, Uses, and Challenges." *Bulletin of the World Health Organization* 82: 601–607.
- Doudeijns, Marco, and Jean-Christophe Dumont. 2003. "Immigration and Labour Shortages: Evaluation of Needs and Selection Policies in the Recruitment of Foreign Labor." Presentation to a joint conference on The Economic and Social Aspects of Migration by the European Commission and the OECD, Brussels, January 21–22.

- Dumont, Jean-Christophe, and J. B. Meyer. 2004. "The International Mobility of Health Professionals: An Evaluation and Analysis Based on the Case of South Africa." In *Trends in International Migration, 2003*. Paris: OECD.
- Durand, Martine. 2004. "Conclusions." In *Migration, for Employment: Bilateral Agreements at a Crossroads*. Paris: OECD.
- "Ensuring Quality Long-Term Care for Older People." 2005. *OECD Observer* (March).
- Esping-Andersen, G. 1990. *The Three Worlds of Welfare Capitalism*. Cambridge, UK: Polity Press.
- Falaknaaz-Mumbai, Syed. 2003. "India Faces Acute Shortage of Teaching Staff in Nursing Colleges." *Healthcare Management* (December): 1–15.
- Federal Ministry of Health and Social Security (Bundesministerium fuer Gesundheit und Soziale Sicherung), Germany. 2005. "Selected Facts and Figures about Long-Term Care Insurance." Available at http://www.bmgs.bund.de/downloads/Pflegevers_Tabellen.pdf
- Friedland, Robert. 2004. "Caregivers and Long-Term Care Needs in the 21st Century: Will Public Policy Meet the Challenge?" *Issue Brief*. Long-Term Care Financing Project. Washington, DC: Georgetown University.
- Friedland, Robert, and Laura Summer. 1999. *Demography Is Not Destiny*. Washington, DC: National Academy on an Aging Society.
- Friedman, Thomas L. 2005. *The World Is Flat: A Brief History of the Twenty-First Century*. New York: Farrar, Straus, and Giroux.
- Gbary, Akpa R. 2005. "Migration and Retention of Health Workers in Africa." Presentation at *Health Equity, Human Resources, and Health Development in Africa*, Abuja, February 8–11.
- George, Sheba. 2005. *When Women Come First: Gender and Class in Transnational Migration*. Berkeley: University of California Press.
- German Federal Ministry of Health and Social Security. 2005. "Selected Facts and Figures about Long-Term Care Insurance." Available at [http://www.bmgs.bund.de/downloads/Selected_Facts_and_Figures_\(04-2005\).pdf](http://www.bmgs.bund.de/downloads/Selected_Facts_and_Figures_(04-2005).pdf).
- Gibson, Mary Jo, Steven R. Gregory, and Sheel M. Pandya. 2003. *Long-Term Care in Developed Countries: A Brief Overview*. Report 2003-13. Washington, DC: AARP Public Policy Institute.

- Gordon, Suzanne. 2005. *Nursing Against the Odds: How Health Care Cost Cutting, Media Stereotypes, and Medical Hubris Undermine Nurses and Patient Care*. Ithaca, NY: Cornell University Press.
- Gori, Cristiano, Alessandra di Maio, and Alessandro Pozzi. 2003. "Long-Term Care for Older People in the Italy." In Adelina Comas-Herrera, Joan Costa-Font, Cristiano Gori, Alessandra di Maio, Concepcio Patxot, Linda Pickard, Alessandro Pozzi, Heinz Rothgang, and Raphael Wittenberg (eds.), *European Study of Long-Term Care Expenditure*. Brussels: European Commission.
- Hagan, Jacqueline Maria. 2004. "Contextualizing Immigrant Labor Incorporation: Legal, Demographic, and Economic Dimensions." *Work and Occupations*, 31 (4): 407–423.
- Hanai, Kiroku. 2004. "Foreign Workers at the Gates." *Japan Times*, August 23.
- Harris-Kojetin, Lauren, Debra Lipson, Jean Fielding, Kristen Kiefer, and Robyn I. Stone. 2004. *Recent Findings on Frontline Long-Term Care Workers: A Research Synthesis 1999–2003*. Washington, DC: Office of the Assistant Secretary for Policy and Evaluation, DHHS.
- Health Resources and Services Administration, DHHS. 2002. *Projected Supply, Demand, and Shortages of Registered Nurses: 2000–2020*. Washington, DC: Health Resources and Services Administration.
- Health Resources and Services Administration, DHHS. 2004. *Nursing Aides, Home Health Aides, and Related Health Care Occupations: National and Local Workforce Shortages and Associated Data Needs*. Washington, DC: Health Resources and Services Administration.
- Hecker, Daniel E. 2004. Occupational Employment Projections to 2012. *Monthly Labor Review, Bureau of Labor Statistics* (February): 80–105.
- Helliwell, John F. 2004. *Demographic Changes and International Factor Mobility*. National Bureau of Economic Research Working Paper No. 10945. Available a: <http://www.nber.org/papers/w10945>
- Holzer, Harry J. 2003. *Modeling the Future Supply and Demand for Long-Term Care Services*. Washington, DC: Institute for the Future of Aging Services.
- Holzmann, Robert, and Rainer Muenz. 2004. *Challenges and Opportunities of International Migration for the EU, Its Member States, Neighboring Countries and Regions: A Policy Note*. Washington, DC: World Bank.

- Home Office, UK. 2005. "Working in the UK" Shortage occupation list. Available at www.workingintheuk.gov.uk/working_in_the_uk/en/homepage/work_permits/applying_for_a_work/business_and_commercial/how_do_i_make_an_application/shortage_occupations.html
- Hoppe, Ron. 2005. "International Recruitment of Health Care Professionals." Presentation to the American Society on Aging, April.
- Howe, Neil, and Richard Jackson. 2005. *Projecting Immigration: A Survey of the Current State of Practice and Theory*. Washington, DC: Center for Strategic and International Studies.
- Iguchi, Yashushi. 2005. "Possibilities and Limitations of Japanese Migration Policy in the Context of Economic Partnership in East Asia." *United Nations Expert Group Meeting on International Migration and Development*. New York: United Nations Population Division. Available at <http://www.un.org/esa/population/publications/ittmigdev2005/P07-iguchi.pdf>.
- Institute of Medicine. 2001. *Improving the Quality of Long-Term Care*. Washington, DC: National Academy Press.
- International Council of Nurses. 2001. "Ethical Nurse Recruitment." Position statement. Available at <http://www.icn.ch/psrecruit01.htm>
- International Organization for Immigration (IOM). 2005. *World Migration 2005: Costs and Benefits of International Migration*. Geneva: IOM.
- Jandl, Martin, and Michael Hofmann. 2004. "Expected Short-Term Effects of EU-Enlargement on Migration—the Case of Austria." *Der Donauraum* (4): 37–43.
- Jenson, Jane, and Stephane Jacobzone. 2000. "Care Allowances for the Frail Elderly and Their Impact on Women Care-givers." *OECD Labour Market and Social Policy Occasional Papers No. 41*. Paris: OECD.
- Johansson, Stina, and Peter Moss. 2004. *Work with Elderly People: A Case Study of Sweden, Spain and England with Additional Material from Hungary*. London: The University of London.
- Kelly, Rachel, Gareth Morrell, and Dhananjayan Sriskandarajah. 2005. *Migration and Health in the UK*. London: Institute for Public Policy Research.
- Khadria, Binod. 2004. "Migration of Highly Skilled Indians: Case Studies of IT and Health Professionals." *OECD Directorate for Science, Technology and Industry Report No. 2004/6*. Paris, OECD.

- Korczyk, Sophie. 2004. *Long-Term Care Workers in Five Countries: Issues and Options*. AARP Public Policy Institute Report No. 2004-07. Washington, DC: AARP.
- Kreimer, Margareta, and Helene Schiffbaenkner. 2003. *A New Austrian Care System?* Vienna: Institute of Technology and Regional Policy.
- Lowell, B. Lindsay. 2005. "Policies and Regulations for Managing Skilled International Migration for Work." Paper presented to the UN Expert Group Meeting on International Migration and Development, New York, July 6–8.
- Lowell, B. Lindsay, Allan Findley, and Emma Stewart. 2004. "Brain Strain: Optimising Highly Skilled Migration from Developing Countries." *Asylum and Migration Working Paper 3*. London: Institute for Public Policy Research.
- Lowell, B. Lindsay, and Stefka Georgieva Gerova. 2004. "Immigration and the Skilled Healthcare Workforce." *Work and Occupations* 31 (4): 474–498.
- Lundsgaard, Jens. 2005. "Consumer Direction and Choice in Long-Term Care for Older Persons, Including Payments for Informal Care: How Can It Improve Care Outcomes, Employment and Fiscal Sustainability?" *OECD Health Working Papers No. 20*. Paris: OECD.
- Mafubelu, Daisy. 2004. "Using Bilateral Arrangements to Manage Migration of Healthcare Workers: The Cases of South Africa and the United Kingdom." Seminar on Health and Migration, June 9–11, Geneva: International Organization for Migration.
- Martineau, Tim, and Annie Willetts. In press. "The Health Workforce: Managing the Crisis: Ethical International Recruitment of Health Professionals: Will Codes of Practice Protect Developing Country Health Systems?" *Health Policy*.
- McKeon, Erin. 2003. "Federal Legislation to Relax Nurse Immigration Standards." *Online Journal of Issues in Nursing*. Available at http://nursingworld.org/ojin/tpclg/leg_13.htm
- Mitchell, Olivia S., John Piggott, and Satoshi Shimizutai. 2004. "Aged Care Support in Japan: Perspectives and Challenges." *NBER Working Paper No. 10882*. Cambridge, MA: National Bureau for Economic Research.
- Muenz, Rainer, and Thomas Straubhaar. 2004. "Migrants and the European Labor Market." *Policy Brief 3* for the Dutch Presidency Conference on Asylum, Migration and Frontiers. Brussels: European Commission.
- National Center for Health Workforce Analysis. 2003. *Changing Demographics: Implications for Physicians, Nurses, and Other Health Workers*. Washington, DC: Health Resource and Services Administration, DHHS.

- National Commission on Nursing Workforce for Long-Term Care. 2005. *Act Now for Your Tomorrow*. Washington, DC: National Commission on Nursing Workforce for Long-Term Care.
- National Council of State Boards of Nursing (NCSBN). 1983–2002. Online annual reports on *Nurse Licensee and NCLEX® Examination Statistics*. Available at http://www.ncsbn.org/testing/psychometrics_nclexlicensure_examstats.asp
- National Health Policy Forum. 2001. *Caring for the Elderly: Oregon's Pioneers*. Washington, DC: George Washington University.
- Nemeth, Claudia, and Elisabeth Pochobradsky. 2004. "Qualitätsicherung in der häuslichen Betreuung [Quality Assurance in Home Care]." Report to the Austrian Federal Ministry for Social Security, Generations, and Consumer Protection by the Österreichisches Bundesinstitut für Gesundheitswesen.
- Nursing and Midwifery Council (UK). 2005. *Statistical Analysis of the Register: 1 April 2003 to 31 March 2004*. London: Nursing and Midwifery Council. Available at <http://www.nmc-uk.org/nmc/main/about/nmcStatistics.html>.
- Office of Minority Health, Department of Health and Human Services (DHHS). 2001. *National Standards for Culturally and Linguistically Appropriate Services in Health Care*. Washington, DC: DHHS.
- Orozco, Manuel. 2003. "Worker Remittances: An International Comparison." *Working Paper*. Washington, DC: Inter-American Development Bank.
- Organisation for Economic Co-operation and Development (OECD). 2004a. *Migration, for Employment: Bilateral Agreements at a Crossroads*. Paris: OECD.
- Organisation for Economic Co-operation and Development (OECD). 2005a. *Long-term Care for Older Persons*. Paris: OECD.
- Organisation for Economic Co-operation and Development (OECD). 2005b. *Trends in International Migration, 2004*. Paris: OECD.
- Paradath, Ashnie, Charlotte Chamberlain, David McCoy, Antoinette Ntuli, Mike Rowson, and Rene Loewenson. 2004. "Health Personnel in Southern Africa: Confronting Maldistribution and Brain Drain." *Equinet Discussion Paper No. 3*. Ottawa, Canada: International Development Research Centre.
- Polverini, Francesca, and Giovanni Lamura. 2004. "Labor Supply and Care Issues: A National Report on Italy." Ancona, Italy: European Foundation for the Improvement of Living and Working Conditions.

- Przywara, Bartosz. 2005. "Projections of Expenditures on Health and Long-Term Care at the EU Level." Presentation to an OECD/European Commission Workshop in Brussels, February 21–22.
- Rauhut, Daniel. 2004. *Replacement Migration to Sweden: A Review of Possible Sender Countries*. Östersund, Sweden: Swedish Institute for Growth Studies.
- Redfoot, Donald L., and Sheel M. Pandya. 2002. *Before the Boom: Trends in Long-Term Supportive Services for Older Americans with Disabilities*. Report No. 2002-15. Washington, DC: AARP Public Policy Institute.
- Rivoli, Pietra. 2005. *The Travels of a T-Shirt in the Global Economy: An Economist Examines the Markets, Power, and Politics of World Trade*. New York: Wiley.
- Robine, Jean-Marie, Carol Jagger, and Herman van Oyen. 2005. "Interpreting International Evidence on the Evolution of Morbidity and Disability Prevalence Over Time and Perspectives for Extended Healthy Life Expectancy." *Joint EU–OECD Workshop*, Brussels.
- Royal College of Nursing, Australia. (2004). *Submission to: The Treasury's Discussion Paper: Australia's Demographic Challenges*. Canberra, Australia: The Treasury Office.
- Royal College of Nursing, UK. (2002). *Valued Equally? The 2002 Survey of RCN Members*. London: Royal College of Nurses.
- Sachs, Jeffrey D. 2005. *The End of Poverty: Economic Possibilities for Our Time*. New York: Penguin Press.
- Sieg, Linda. 2004. "Japan, Philippines FTA Shows Foreign Worker Hurdles." *Reuters* (November 29).
- Simoens, Steven, Michael Villeneuve, and Jeremy Hurst. 2005. "Tackling Nurse Shortages in OECD Countries." *OECD Health Working Papers No. 19*. Paris: OECD. Available at <http://www.oecd.org/dataoecd/11/10/34571365.pdf>
- Smith, Tamsin. 2005. "Ageing Italy Leans on Immigrants." British Broadcasting Corporation report, January 4.
- Smith, June, and Lynda Crawford. 2004. *Report of Findings from the Practice and Professional Issues Survey*. Chicago, IL: National Council of State Boards of Nursing.
- Socialstyrelsen. 2005. "Invest Now—Action Plan for Manpower Supply in the Care Services." English summary available at <http://www.socialstyrelsen.se/Publicerat/2004/8481/Summary.htm>

- Sorensen, Ninna N. 2004. *The Development Dimension of Migrant Remittances*. Geneva: International Organization for Migration.
- South African Nursing Council. 2005. "Statistics of the South African Nursing Council." Available at <http://www.sanc.co.za/stats.htm>
- Spratley, Ernell, Ayah Johnson, Julie Solchalski, Marshall Fritz, and William Spencer. 2000. *The Registered Nurse Population: Findings from the National Sample Survey of Registered Nurses*. Washington, DC: Health Resources and Service Administration (DHHS).
- Sriskandarajah, Dhananjayan. 2004. "Labor Migration to the UK: An IPPR FactFile." London: Institute for Public Policy Research.
- Sriskandarajah, Dhananjayan. 2005. "Migration Can Aid Development." *Financial Times*, April, 13, p. 13.
- Standing Committee of Nurses of the European Union. 2005. "PCN Good Practice Guidance for International Nurse Recruitment." Brussels: European Union.
- Stewart, Michael. 2005. "Texas Nurse a Leader in Uncovering Visa Scam." *American Nurse*. Available at <http://www.nursingworld.org/tan/98marapr/spotligh.htm>
- Stilwell, Barbara, Khassoum Diallo, Pascal Zurn, Mario R. Dal Poz, Orville Adams, and James Buchan. 2003. "Developing Evidence-Based Ethical Policies on the Migration of Health Workers: Conceptual and Practical Challenges." *Human Resources for Health* 1: 8.
- Stilwell, Barbara, Khassoum Diallo, Pascal Zurn, Marko Vujicic, Orville Adams, and Mario Dal Poz. 2004. "Migration of Health-Care Workers from Developing Countries: Strategic Approaches to Its Management." *Bulletin of the World Health Organization* 82: 595–600.
- Stone, Robyn I., and Joshua M. Wiener. 2001. *Who Will Take Care of Us? Addressing the Long-Term Care Workforce Crisis*. Washington, DC: Urban Institute.
- Sussex Centre for Migration Research. 2002. "Harnessing Migration Potential for Development: Examples from West Africa." *Sussex Migration Briefing* No. 1 (July).
- Tebeje, Ainalem. 2005. "Brain Drain and Capacity Building in Africa." International Development Research Centre. Available at http://web.idrc.ca/en/ev-71249-201-1-DO_TOPIC.html
- Tiemoko, Richard. 2003. "Migration, Return and Socio-Economic Change in West Africa: The Role of Family." *Sussex Migration Working Paper No. 15*. Sussex, UK: Sussex Centre for Migration Research.

- Ungerson, Clare. 2004. "Whose Empowerment and Independence? A Cross-National Perspective on 'Cash for Care' Schemes." *Ageing and Society* 24: 189–212.
- United Nations. 2005. *The Millennium Development Goals Report*. New York: United Nations.
- United Nations Department of Social and Economic Affairs. 2004. *World Economic and Social Survey 2004: International Migration*. New York: United Nations.
- United Nations Population Division. 2000. *Replacement Migration: Is It a Solution to Declining and Ageing Populations?* New York: United Nations.
- United Nations Population Division. 2005. *World Population Prospects: The 2004 Revision*. New York: United Nations. Online data for countries and regions available at <http://esa.un.org/unpp/>
- U.S. Census Bureau. 1980. *Statistical Abstract of the U.S., 1980*, Washington, DC: Census Bureau.
- U.S. Census Bureau. 2005. *Statistical Abstract of the U.S., 2004–2005*, Washington, DC: Census Bureau.
- U.S. Department of Health and Human Resources (DHHS). 2003. *The Future Supply of Long-Term Care Workers in Relation to the Aging Baby Boom Generation: A Report to Congress*. Washington, DC: DHHS.
- Van Eyck, Kim. 2004. *Women and International Migration in the Health Sector*. Ferney-Voltaire, France: Public Services International.
- Vujicic, Marko, Pascal Zurn, Khassoum Diallo, Orville Adams, and Mario R Dal Poz. 2004. "The Roles of Wages in the Migration of Health Care Professionals from Developing Countries." *Human Resources for Health* 3 (2). Available at <http://www.human-resources-health.com/content/pdf/1478-4491-2-3.pdf>
- Waldman, Amy. 2005. "Sri Lankan Maids Pay Dearly for Perilous Jobs Overseas." *New York Times*, May 8.
- Wattenberg, Ben J. 2004. *Fewer: How the New Demography of Depopulation Will Shape Our Future*. Chicago: Ivan R. Dee.
- Welford, Richard. 2004. "Debate over Philippines Nurses in Japan." *Corporate Social Responsibility in Asia*. Available at <http://www.csr-asia.com/index.php/archives/2004/08/19/debate-over-philippines-nurses-in-japan/trackback/>

- World Bank. 2003. *Global Development Finance, 2004: Appendix A—Enhancing the Developmental Effect of Workers' Remittances to Developing Countries*. Washington, DC: World Bank.
- World Health Organization (WHO). 2004. *The Migration of Skilled Health Personnel in the Pacific Region*. Manila, Philippines: WHO Western Pacific Region.
- World Health Organization (WHO). 2005. *Global Health Atlas*. Geneva: World Health Organization. Available at www.who.int/globalatlas/default.asp

Appendix A—Analysis of Census Data and Comparability between Years

Within this document, we use public use microdata files from the decennial U.S. Census and the annual American Community Survey to determine the number and characteristics of nurses and nurse aides in health care and long-term care settings. We have developed the definitions of these groups to select as many nurses and aides as possible using the occupation and industry codes in the Census Bureau data sets, while minimizing the inclusion of other types of workers. Maximizing the comparability of the groups between 1980–90 and 2000–03 presented challenges, since census occupation and industry codes changed between 1990 and 2000. Table A1 maps the occupation and industry codes used in the source data to the occupation and setting categories used in this report.

Table A1: Definitions of Occupation and Setting (Industry) Categories Used in This Report, 1980–90 (1990 codes) and 2000–03 (2000 codes)

Nurses (1990 occupation codes)

095 Registered nurses

207 Licensed practical nurses

Nurses (2000 occupation codes)

313 Registered nurses

350 Licensed practical and licensed vocational nurses

Aides (1990 occupation codes)

446 Health aides, except nursing

447 Nursing aides, orderlies, and attendants

Aides (2000 occupation codes)

360 Nursing, psychiatric, and home health aides

365 Medical assistants and other health care support occupations

461 Personal and home care aides

Hospital Settings (1990 industry codes)

831 Hospitals

Hospital Settings (2000 industry codes)

819 Hospitals

Long-Term Care Settings (1990 industry codes)

832 Nursing and personal care facilities

870 Residential care facilities, without nursing

Long-Term Care Settings (2000 industry codes)

827 Nursing care facilities

829 Residential care facilities, without nursing

Home Health Care Settings (1990 industry codes)

N/A

Home Health Care Settings (2000 industry codes)

817 Home health care services

Other Health Care Settings (1990 industry codes): 812–840 unless otherwise assigned

Other Health Care Settings (2000 industry codes): 797–829 unless otherwise assigned

In addition, we typically limit the occupation categories to only health care settings or to only long-term care settings. Unless otherwise noted in the text, census data concerning nurses or aides have been filtered so that they contain only workers working in a health care setting (hospital, long-term care, home health, or other health care).

As a result of the change in occupation and industry codes used to establish these groups, the data are not entirely comparable between 1980–90 and 2000–03. However, the vast majority of workers in each of these groups are captured by both coding schemes, and comparisons between 2000–03 data and earlier results are still informative.

Tables A2–A6 below show the comparability between the periods 1980–90 and 2000–03 by comparing data from the 1990 decennial census sorted by 1990 occupation and industry codes, and the same data redistributed into the 2000 occupation and industry codes. Note that the count of the number of workers is from the entire sample and includes non-health care settings in the occupation categories and non-health care occupations in the setting/industry categories. With the exception of the “aide” occupation category, there is 95 percent or higher commonality among all of the groupings used in our analysis; that is, at least 95 percent of the workers in each category using one coding scheme were in the same category using the other coding scheme.

Within the “aides” category, about 90 percent of those identified as aides by the 1990 occupation codes were still identified as aides using the 2000 codes, and more than 95 percent were still in health care occupations in 2000. However, only 80 percent of those identified as aides using the 2000 codes were identified as aides using the 1990 codes, as there was significant “migration” into this group. More than half of these additions came from what were previously non-health occupations, including cashiers, private household cleaners and servants, animal caretakers, welfare service aides, and administrative support occupations.

Some caution should be used when comparing the characteristics and demographics of aides from 1990 or earlier with those from 2000 and after, particularly in terms of raw counts, since the 2000 occupation codes seem to inflate the number of aides by about 10 percent relative to the 1990 codes. We expect that comparisons limiting aides to health care or long-term care settings would increase the comparability between years, and we do so in this report wherever possible.

Table A2: Comparability of Nurses—1990 Census Data—Numbers of Workers by 1990 Occupation Categories and Redistributed into 2000 Occupation Categories

| Occupation Category (1990 occupation codes) | Occupation Category (2000 occupation codes) | Number of Workers | % of 1990 Nurses | % of 2000 Nurses |
|--|--|--------------------------|-------------------------|-------------------------|
| Nurses | Aides | 38,472 | 1.7 % | |
| Nurses | Nurses | 2,276,130 | 98.3 % | 98.7 % |
| Aides | Nurses | 31,379 | | 1.3 % |

Table A3: Comparability of Aides—1990 Census Data—Numbers of Workers by 1990 Occupation Categories and Redistributed into 2000 Occupation Categories

| Occupation Category (1990 occupation codes) | Occupation Category (2000 occupation codes) | Number of Workers | % of 1990 Aides | % of 2000 Aides |
|--|--|--------------------------|------------------------|------------------------|
| Aides | Non-health care | 84,456 | 4.4 % | |
| Aides | Other health care | 87,569 | 4.6 % | |
| Aides | Nurses | 31,379 | 1.6 % | |
| Aides | Aides | 1,714,639 | 89.4 % | 80.7 % |
| Nurses | Aides | 38,472 | | 1.8 % |
| Other health care | Aides | 150,034 | | 7.1 % |
| Non-health care | Aides | 222,368 | | 10.5 % |

Table A4: Comparability of Hospital Settings—1990 Census Data—Numbers of Workers by 1990 Industry Categories and Redistributed into 2000 Industry Categories

| Setting Category (1990 industry codes) | Setting Category (2000 industry codes) | Number of Workers | % of 1990 Hospital | % of 2000 Hospital |
|---|---|--------------------------|---------------------------|---------------------------|
| Hospitals | Hospitals | 5,329,531 | 100.0 % | 99.7 % |
| Hospitals | Long-term care | 15,536 | | 0.3 % |

Table A5: Comparability of Long-Term Care Settings—1990 Census Data—Numbers of Workers by 1990 Industry Categories and Redistributed into 2000 Industry Categories

| Setting Category (1990 industry codes) | Setting Category (2000 industry codes) | Number of Workers | % of 1990 Long-Term Care | % of 2000 Long-Term Care |
|---|---|--------------------------|---------------------------------|---------------------------------|
| Long-term care | Non-health care | 25,989 | 1.5 % | |
| Long-term care | Other health care | 50,563 | 2.9 % | |
| Long-term care | Hospitals | 15,536 | 0.9 % | |
| Long-term care | Long-term care | 1,672,425 | 94.7 % | 95.9 % |
| Non-health care | Long-term care | 70,737 | | 4.1 % |

**Table A6: Comparability of Other Health Care Settings—1990 Census Data—
Numbers of Workers by 1990 Industry Categories and Redistributed into 2000
Industry Categories**

| Setting Category (1990 industry codes) | Setting Category (2000 industry codes) | Number of Workers | % of 1990 Other Health Care | % of 2000 Other Health Care |
|---|---|----------------------------------|--|--|
| Other health care | Non-health care | 155,632 | 4.9 % | |
| Other health care | Other health care | 3,036,315 | 95.1 % | 96.3 % * |
| Long-term care | Other health care | 50,563 | | 1.6 % * |
| Non-health care | Other health care | 65,090 | | 2.1 % * |

All population figures for 1990 (and 1990 redistributed into 2000 occupation and industry codes) in this appendix are from U.S. Census Bureau, *The Relationship Between the 1990 Census and Census 2000 Industry and Occupation Classification Systems*, Technical Paper 65, 2003.

Appendix B—Detailed Data on International Long-Term Workers in the United States

Many observers suggest that staffing shortages are the most critical quality problem in long-term care. The National Commission on Nursing Workforce for Long-Term Care (2005) reported vacancy rates in U.S. nursing homes of 15 percent for RNs, 13 percent for practical nurses, and 8.5 percent for certified nurse assistants (CNAs). Local vacancy rates are often much higher. Nursing homes would need another 96,000 full-time equivalent staff to be fully staffed.

Growing numbers of international workers are immigrating to the United States to fill these vacancies, but demographic trends do not appear to be the cause of this migration. The nurse to population ratio is at an all-time high in the United States (Lowell and Gerova, 2004). Moreover, the overall “dependency ratio” is near all-time lows, and even the old age dependency ratio has not increased much. The future U.S. demographic picture is more favorable than it is in most other developed countries. In 2030, the United States will be demographically similar to many European countries and Japan today.

Shortages appear to be more related to general declines in the attractiveness of nursing as a profession as well as the low prestige of long-term care work. The number of new native-born nurses graduating each year declined by 26 percent between 1995 and 2000 (Aiken, 2005). Recent wage improvements for nurses have increased recruitment of new native-born nurses and the return of older nurses (Buerhaus, Staiger, and Auerbach, 2004), but the stream of foreign workers continues.

I. Migration and the Impact on Health and Long-Term Care Workforce

A. Historical Trends in Immigration to the United States

One of every five migrants in the world lives in the United States (UN Department of Social and Economic Affairs, 2004). After decreasing in the middle of the 20th century from earlier waves, immigration in the United States has entered another period of expansion, in both numbers of immigrants and as a proportion of the total population. Indeed, as Hagan (2004) notes, more people immigrated to the United States in the 1990s than in any other decade in the nation’s history. Roughly seven million of the total 34 million foreign-born persons in the United States are undocumented (OECD, 2005b).

Table B1: Rate and Number of Immigrants to the United States, by Period

| | Immigration Rate (annual number per 1000 population) | Number of Immigrants (in thousands) |
|------------------|---|--|
| 1901–1910 | 10.4 | 8,795 |
| 1911–1920 | 5.7 | 5,736 |
| 1921–1930 | 3.5 | 4,107 |
| 1931–1940 | 0.4 | 528 |
| 1941–1950 | 0.7 | 1,035 |
| 1951–1960 | 1.5 | 2,515 |
| 1961–1970 | 1.7 | 3,322 |
| 1971–1980 | 2.1 | 4,493 |
| 1981–1990 | 3.1 | 7,338 |
| 1991–2000 | 3.4 | 9,095 |
| 2001 | 3.7 | 1,064 |
| 2002 | 3.7 | 1,064 |

Source: U.S. Census Bureau, *Statistical Abstract of the U.S., 2004–2005*

The number of foreign-born people in the United States has more than doubled over the past two decades to 33.5 million. As a result, the percentage of the U.S. population that is foreign born has risen in recent years to levels not seen since the early part of the 20th century.

Table B2: Foreign-Born Population, Total and Percentage of U.S. Population

| | Foreign-Born as Percent of U.S. Population | Number of Foreign-Born Persons in U.S. (millions) |
|-------------|---|--|
| 1900 | 13.6% | 10.3 |
| 1910 | 14.7% | 13.5 |
| 1920 | 13.2% | 13.9 |
| 1930 | 11.6% | 14.2 |
| 1940 | 8.8% | 11.6 |
| 1950 | 6.9% | 10.3 |
| 1960 | 5.4% | 9.7 |
| 1970 | 4.8% | 9.6 |
| 1980 | 6.2% | 14.1 |
| 1990 | 7.9% | 19.8 |
| 2000 | 11.1% | 31.1 |
| 2003 | 11.7% | 33.5 |

Sources: U.S. Census Bureau, *Statistical Abstract of the United States, 1980 and 2004–2005*

B. Trends in the Number of Foreign-Born Long-Term Care (LTC) Workers

Although health care workers represent only about 4 percent of all foreign-born persons in the United States, their numbers have grown substantially, especially in long-term care settings. The number of foreign-born nurse aides in long-term care settings increased fourfold between 1980 and 2003, more than doubling the proportion of foreign-born aides in such settings from 6 percent to 16 percent. Growth was even more dramatic among foreign-

born nurses, as their numbers grew more than sixfold, and the proportion of foreign-born nurses in long-term settings also increased from 6 percent to 16 percent.

Table B3: Foreign-Born Nurses and Nurse Aides in LTC Settings, 1980–2003

| | 1980 | 1990 | 2000 | 2003 ACS |
|--|--------|--------|---------|----------|
| Foreign-born nurses, % of total | 6% | 7% | 13% | 16% |
| Number of foreign-born nurses | 9,900 | 17,700 | 51,000 | 64,000 |
| Foreign-born aides, % of total | 6% | 9% | 14% | 16% |
| Number of foreign-born aides | 34,000 | 71,000 | 115,000 | 145,000 |

Sources: U.S. 1980–2000 Census and American Community Survey 2003, AARP PPI analysis

C. Where Do International Workers Come From?

Among both foreign-born aides and nurses, the percentage of persons of European origin has declined while the percentage of persons of African origin has increased. Nearly half of foreign-born nurse aides come from Mexico and Central America, including the Caribbean nations. Among nurses, the largest regional group is from Asia, mostly the Philippines.

Table B4: Regions of Origin—Foreign-Born Nurses in LTC Settings, 1980–2000

| Region | 1980 | 1990 | 2000 |
|---|-------------|-------------|--------------|
| North America & U.S. Islands | 1,680 (17%) | 2,200 (12%) | 3,100 (6%) |
| Central America & Mexico | 1,700 (17%) | 4,900 (27%) | 13,100 (26%) |
| South America | 400 (4%) | 530 (3%) | 2,000 (4%) |
| Europe | 2,500 (26%) | 4,000 (22%) | 6,800 (13%) |
| Asia | 3,300 (33%) | 5,500 (31%) | 20,000 (40%) |
| Africa | 260 (3%) | 580 (3%) | 5,500 (11%) |
| Australia/Oceania | 40 (< 0.5%) | 127 (1%) | 270 (1%) |
| Total | 9,900 | 17,700 | 51,000 |

Source: U.S. Census data, AARP PPI analysis

Table B5: Regions of Origin—Foreign-Born Nurse Aides in LTC Settings, 1980–2000

| Region | 1980 | 1990 | 2000 |
|---|--------------|--------------|--------------|
| North America & U.S. Islands | 3,900 (12%) | 6,200 (9%) | 7,400 (6%) |
| Central America & Mexico | 12,000 (36%) | 31,000 (43%) | 53,000 (46%) |
| South America | 1,760 (5%) | 4,400 (6%) | 6,200 (5%) |
| Europe | 9,300 (28%) | 12,200 (17%) | 12,900 (11%) |
| Asia | 5,700 (17%) | 13,600 (19%) | 22,000 (19%) |
| Africa | 700 (2%) | 3,400 (5%) | 12,600 (11%) |
| Australia/Oceania | 320 (1%) | 560 (1%) | 1,180 (1%) |
| Total | 34,000 | 71,000 | 115,000 |

Source: U.S. Census data, AARP PPI analysis

Tables B6 and B7 display look at the length of residence among foreign-born nurses and nurse aides by region of origin. Nearly 37 percent of each group has been in the United States for less than 10 years. The relatively high percentage of Asians and Africans and the

declining percentage of Europeans among both nurses and nurse aides clearly demonstrate the changing patterns of migration among long-term care workers.

Table B6: Percentage of Foreign-Born Nurses in LTC Settings from Various Regions and Countries, by Length of Residence in the United States, 2000

| | 0–10 years | 11–20 years | 21+ years |
|---|-------------------|--------------------|------------------|
| Caribbean, Puerto Rico, U.S. Islands | 12% | 31% | 27% |
| Canada | 3% | < 0.5% | 7% |
| Central America, Mexico | 3% | 6% | 7% |
| South America | 3% | 6% | 3% |
| Europe | 8% | 7% | 26% |
| Philippines | 39% | 22% | 11% |
| India | 6% | 7% | 4% |
| Other Asia | 8% | 9% | 10% |
| Africa | 17% | 11% | 4% |
| Australia, Oceania | < 0.5% | 1% | < 0.5% |
| Total number of foreign-born nurses | 18,700 | 15,900 | 16,300 |

Source: U.S. Census data, AARP PPI analysis

Table B7: Percentage of Foreign-Born Nurse Aides in LTC Settings from Various Regions and Countries, by Length of Residence in the United States, 2000

| | 0–10 years | 11–20 years | 21+ years |
|---|-------------------|--------------------|------------------|
| Caribbean, Puerto Rico, U.S. Islands | 26% | 42% | 36% |
| Canada | 1% | 1% | 3% |
| Central America, Mexico | 12% | 18% | 20% |
| South America | 5% | 7% | 5% |
| Europe | 10% | 6% | 19% |
| Philippines | 17% | 11% | 6% |
| India | 2% | 2% | 1% |
| Other Asia | 5% | 6% | 7% |
| Africa | 22% | 6% | 3% |
| Australia, Oceania | 2% | 1% | < 0.5% |
| Total # of foreign-born nurse aides | 43,000 | 40,000 | 32,000 |

Source: U.S. Census data, AARP PPI analysis

II. Demographic Characteristics of International Workers

A. Gender

As with their native-born counterparts, both foreign-born nurses and aides are overwhelmingly women. But foreign-born nurses and nurse aides are both more likely to be men than are their native-born counterparts.

Table B8: Gender of Nurses and Nurse Aides by Nativity, 2000

| | Nurses | | Nurse Aides | |
|----------------|---------------------|--------------------|---------------------|--------------------|
| | Foreign-Born | Native-Born | Foreign-Born | Native-Born |
| Males | 10% | 6% | 13% | 9% |
| Females | 90% | 94% | 87% | 91% |

Source: U.S. Census data, AARP PPI analysis

B. Age

Reflecting the fact that many have recently arrived in this country, foreign-born nurses are somewhat younger than their native-born counterparts. The opposite is the case for nurse aides. One-quarter of native-born nurse aides were younger than age 25 in 2000, compared to less than one-tenth of foreign-born aides, perhaps because nurse aide positions are more likely to be considered entry-level jobs for the native born.

Table B9: Age of Nurses and Nurse Aides in LTC Settings, by Nativity, 2000

| | Nurses | | Nurse Aides | |
|------------------------|---------------------|--------------------|---------------------|--------------------|
| | Foreign-Born | Native-Born | Foreign-Born | Native-Born |
| Less than 25 | 3% | 5% | 10% | 25% |
| 25–34 years old | 28% | 20% | 22% | 24% |
| 35–44 | 33% | 28% | 31% | 23% |
| 45–54 | 23% | 28% | 24% | 16% |
| 55–64 | 20% | 14% | 11% | 9% |
| 65+ | 2% | 4% | 2% | 3% |
| Median age | 40 | 43 | 40 | 35 |

Source: U.S. Census data, AARP PPI analysis

The age difference reverses for recently licensed nurses. Native-born nurses come directly out of nursing schools, while foreign-born nurses generally worked for a number years in their home country before coming to the United States.

Table B10: Average Age of Registered and Practical Nurses Who Passed Their Exams between September 1 and November 30, 2002

| | Foreign-Educated | U.S.-Educated |
|--------------------------|-------------------------|----------------------|
| Registered nurses | 34 | 31 |
| Practical nurses | 35 | 32 |

Source: Smith and Crawford, 2004

C. Race/Ethnicity and Nationality

The long-term care workforce is becoming more racially diverse, especially among the foreign born. The percentage of white foreign-born nurses and aides has declined as the percentage from Europe has declined. The percentages of black and Asian foreign-born nurses have increased, along with the percentages from Africa, the Caribbean, and Asia.

Table B11: Race/Ethnicity of Nurses in LTC Settings, 1980–2000

| | Foreign-Born | | | Native-Born | | |
|--------------------|--------------|------|------|-------------|------|------|
| | 1980 | 1990 | 2000 | 1980 | 1990 | 2000 |
| Asian | 29% | 29% | 38% | 0.1% | 0.2% | 0.2% |
| Black | 16% | 24% | 30% | 10% | 13% | 15% |
| Hispanic | 9% | 14% | 9% | 1% | 2% | 2% |
| Other/Mixed | 1% | 0.2% | 6% | 1% | 1% | 2% |
| White | 45% | 33% | 18% | 88% | 84% | 81% |

Source: U.S. Census data, AARP PPI analysis

Table B12: Race/Ethnicity of Nurse Aides in LTC Settings, 1980–2000

| | Foreign-Born | | | Native-Born | | |
|--------------------|--------------|------|------|-------------|------|------|
| | 1980 | 1990 | 2000 | 1980 | 1990 | 2000 |
| Asian | 15% | 18% | 19% | 0.1% | 0.1% | 0.4% |
| Black | 28% | 36% | 37% | 21% | 26% | 29% |
| Hispanic | 20% | 25% | 24% | 3% | 3% | 5% |
| Other/Mixed | 1% | 1% | 7% | 1% | 1% | 3% |
| White | 36% | 21% | 14% | 75% | 69% | 63% |

Source: U.S. Census data, AARP PPI analysis

More than half of the nurses taking the NCLEX-RN® licensing examination since 2000 have been from the Philippines. Second-place Canada has declined to less than 10 percent.

Table B13: Numbers and Percentages of First-Time, Internationally Trained RN Candidates for U.S. Licensure Examination from Selected Countries, 1999–2003

| | 1999 | 2000 | 2001 | 2002 | 2003 |
|--------------------|-------------|-------------|-------------|-------------|-------------|
| Philippines | 1,853 (29%) | 3,335 (44%) | 4,456 (52%) | 4,456 (56%) | 9,414 (57%) |
| Canada | 1,368 (21%) | 1,093 (15%) | 1,012 (12%) | 1,344 (11%) | 1,425 (9%) |
| India | 369 (6%) | 414 (6%) | 391 (5%) | 743 (6%) | 1,227 (7%) |
| Korea | 732 (11%) | 637 (8%) | 542 (6%) | 969 (8%) | 1,047 (6%) |
| UK | 256 (4%) | 272 (4%) | 290 (3%) | 326 (4%) | 333 (2%) |
| Nigeria | 236 (4%) | 229 (3%) | 194 (2%) | 272 (2%) | 328 (2%) |
| Total | 6,381 | 7,506 | 8,613 | 12,723 | 16,490 |

Source: Online data from the National Council of State Boards of Nursing

D. Characteristics of Foreign-Born Workers in Long-Term Care Settings Compared with Workers in Other Health Care Settings

Though they come from the same labor pool in many respects, foreign-born workers in long-term care settings differ in significant ways from foreign-born workers in other health care settings. They are somewhat younger, more recent immigrants, and more likely to be black than are foreign-born workers in other health care settings, and foreign-born nurses in long-term care settings receive significantly lower pay.

Table B14: Select Characteristics of Foreign-Born Nurses and Nurse Aides in LTC Compared with Other Health Care Settings in the United States, 2000

| | Nurses | | Nurse Aides | |
|--|---------------------|------------------------------|---------------------|------------------------------|
| | LTC Settings | Other Health Settings | LTC Settings | Other Health Settings |
| Percent male | 10% | 10% | 13% | 14% |
| Median age | 40 | 42 | 40 | 42 |
| Age <35 | 31% | 25% | 32% | 28% |
| < 10 years in U.S. | 37% | 24% | 37% | 31% |
| Median income | \$33,000 | \$42,700 | \$16,500 | \$16,000 |
| Foreign-born Workers in Each Setting from the Following Racial/Ethnic Groups: | | | | |
| Asian | 38% | 41% | 19% | 18% |
| Black | 30% | 18% | 37% | 26% |
| Hispanic | 9% | 11% | 24% | 35% |
| White | 18% | 26% | 14% | 16% |
| Other/Mixed | 6% | 4% | 7% | 5% |

Source: U.S. Census data, AARP PPI analysis

III. Where Do International Workers Go?

A. Setting

Table B15 shows two trends among foreign-born health care workers. First, the percentage of foreign-born health care workers in long-term care settings has increased steadily as the percentage of native-born health care workers in such settings has slipped slightly. Second, in all of the periods reported in the table, more recent immigrants were much more likely to work in long-term care settings than were workers who had been in the country for longer periods. Long-term care may be increasing as an entry-level occupation for foreign-born workers who move on to other settings after a period of time.

Table B15: Percentage and Number of Health Care Workers Who Worked in LTC Settings, by Length of Residence in the United States, 1980–2003

| | 1980 | 1990 | 2000 | 2003 ACS |
|--|-------------|-------------|-------------|-----------------|
| Total foreign-born health care workers in LTC | 46,000 | 93,000 | 177,000 | 220,000 |
| 0–5 years | 22% | 19% | 16% | 26% |
| 6–10 years | 20% | 21% | 21% | 20% |
| 11–15 years | 17% | 15% | 18% | 17% |
| 16–20 years | 10% | 14% | 15% | 14% |
| 21+ years | 23% | 31% | 29% | 22% |
| Total % of LTC workers who are foreign born | 6.2% | 8.6% | 13.7% | 15.9% |

Source: U.S. Census data, AARP PPI analysis

B. Regions and States in the United States

Foreign-born long-term care workers are not distributed evenly throughout the United States; they are more likely to be found in the West and Northeast than in the Midwest or South.

Table B16: Percentage of Nurses and Nurses Aides in LTC Settings Who Were Foreign Born, by Region, 1980–2000

| | Nurses | | | Nurse Aides | | |
|------------------|--------|------|------|-------------|------|------|
| | 1980 | 1990 | 2000 | 1980 | 1990 | 2000 |
| Midwest | 4% | 4% | 6% | 2% | 3% | 5% |
| Northeast | 9% | 10% | 19% | 13% | 17% | 24% |
| South | 3% | 5% | 11% | 3% | 6% | 10% |
| West | 10% | 15% | 24% | 12% | 18% | 27% |

Source: U.S. Census data, AARP PPI analysis

Foreign-born long-term care workers are concentrated in a few states. The top two states, New York and California, accounted for 37 percent of foreign-born nurse aides and 33 percent of foreign-born nurses in long-term care settings in 2000. In California, the proportion of long-term care workers who were foreign born more than doubled among nurse aides, to 45 percent, and more than tripled among nurses, to 43 percent.

Table B17: Top Five States in Number of Foreign-Born Nurse Aides in LTC Settings and Percentage of Foreign-Born Nurse Aides in These States, 1980–2000

| | 1980 | 1990 | 2000 |
|----------------------|--------------|--------------|--------------|
| New York | 10,900 (24%) | 17,500 (29%) | 22,000 (36%) |
| California | 3,700 (20%) | 10,800 (33%) | 20,000 (45%) |
| Florida | 1,300 (9%) | 6,700 (19%) | 10,900 (29%) |
| Massachusetts | 2,100 (9%) | 4,900 (17%) | 7,500 (32%) |
| New Jersey | 1,660 (12%) | 4,858 (25%) | 7,400 (37%) |
| Total | 34,000 | 71,000 | 115,000 |

Source: U.S. Census data, AARP PPI analysis

Table B18: Top Five States in Number of Foreign-Born Nurses in LTC Settings and Percentage of Foreign-Born Nurses Who Were in These States, 1980–2000

| | 1980 | 1990 | 2000 |
|-------------------|-------------|-------------|-------------|
| New York | 2,800 (16%) | 3,800 (18%) | 9,400 (30%) |
| California | 880 (14%) | 3,000 (28%) | 7,500 (43%) |
| Florida | 340 (7%) | 1,440 (12%) | 5,300 (24%) |
| New Jersey | 620 (11%) | 1,110 (13%) | 3,900 (32%) |
| Illinois | 1,000 (11%) | 1,460 (12%) | 3,400 (19%) |
| Total | 9,900 | 17,700 | 51,000 |

Source: U.S. Census data, AARP PPI analysis

C. Metro Location

One major trend among recent international migrants is their urban destination (Helliwell, 2004). Both nurse aides and nurses fit this general pattern—their percentages in a central city are more than twice the percentage of their native-born counterparts. Although the percentage of both foreign-born aides and nurses in long-term care settings in central cities has decreased since 1980, the offsetting increases have been in other metropolitan locations. Only a very small percentage of foreign-born long-term care workers are in nonmetro locations where more than one-quarter of native-born workers are located.

Table B19: Nurses in LTC Settings, by Metro Location, 1980–2000

| | Foreign-Born | | Native-Born | |
|-----------------------------------|--------------|------|-------------|------|
| | 1980 | 2000 | 1980 | 2000 |
| Central city | 35% | 27% | 14% | 10% |
| Metro, not in central city | 41% | 41% | 32% | 27% |
| Metro, unknown | 11% | 25% | 18% | 26% |
| Not metro | 9% | 4% | 22% | 26% |
| Not applicable | 5% | 3% | 14% | 10% |

Source: U.S. Census data, AARP PPI analysis

Table B20: Nurse Aides in LTC Settings, by Metro Location, 1980–2000

| | Foreign-Born | | Native-Born | |
|-----------------------------------|--------------|------|-------------|------|
| | 1980 | 2000 | 1980 | 2000 |
| Central city | 45% | 33% | 16% | 15% |
| Metro, not in central city | 30% | 33% | 3% | 19% |
| Metro, unknown | 12% | 27% | 18% | 27% |
| Not metro | 7% | 5% | 28% | 29% |
| Not applicable | 6% | 3% | 15% | 11% |

Source: U.S. Census data, AARP PPI analysis

A different way to look at the concentration of foreign-born long-term care workers in metro locations is to note the percentage of staff of long-term care facilities who are foreign born. In 2000, more than a quarter of aides and nurses in long-term care settings in central cities are foreign born, roughly doubling their percentages of two decades earlier. The percentages in other metro locations have also increased substantially, but the percentage of workers in nonmetro long-term care settings remains very small.

Table B21: Percentage of Nurses and Nurse Aides in LTC Settings Who are Foreign-Born, by Metro Status, 1980–2000

| | Nurses | | Nurse Aides | |
|-----------------------------------|--------|-------|-------------|-------|
| | 1980 | 2000 | 1980 | 2000 |
| Central city | 13.5% | 28% | 15.4% | 27% |
| Metro, not in central city | 7.4% | 18.6% | 7.9% | 23% |
| Metro, unknown | 3.5% | 12.2% | 4.5% | 14.0% |
| Not metro | 2.4% | 2.4% | 1.6% | 2.8% |
| Not applicable | 2.3% | 4.6% | 2.7% | 3.7% |

Source: U.S. Census data, AARP PPI analysis

IV. Immigration

National Council of State Boards of Nursing research indicates that working as a nurse was the most important reason given for immigrating among foreign-trained registered and practical nurses. Family reasons or living in the United States were less frequently given reasons for immigrating. These data may indicate that the immigration of women is becoming more motivated by independent professional aspirations.

Table B22: Primary Reasons for Coming to the United States

| | Registered Nurses | Practical Nurses |
|--|-------------------|------------------|
| To work as a nurse | 46% | 31% |
| To remain with family going to the U.S. | 19% | 27% |
| To live in the U.S. | 16% | 26% |
| Other | 19% | 16% |

Source: Smith and Crawford, 2004

The percentage of immigrating nurses in the United States with permanent visas is higher than in many European countries, where nurses typically receive a series of “temporary” visas.

Table B23: Initial U.S. Visa Categories of Foreign Nurse Graduates

| Visa Category | RNs | LPNs |
|------------------------|-------|-------|
| Green card (permanent) | 43.6% | 61.8% |
| NAFTA trade status | 12.7% | NA |
| Spousal/Family | NA | 12.7% |
| Tourist | 5.1% | 9.2% |
| H-1 A (temporary) | 4.1% | NA |
| H-1 B (temporary) | 3.7% | NA |
| Refugee status | 2.3% | 4.0% |
| H-2 B (temporary) | 1.8% | NA |
| U.S. citizen | 1.5% | NA |
| Other* | 15.5% | 4.0% |
| Unknown | 9.9% | 2.0% |

*Includes student, medical, and military as well as D, E, F, H, K, and L visas.

Sources: CGFNS (2002 and 2005)

IV. Quality and International Long-Term Care Workers

Unfortunately, no research actually measures differences in quality outcomes based on where long-term care staff were born or educated. The following data, therefore, use surrogate measures related to quality. In general, foreign-born or -educated workers compare very favorably with their native-born counterparts in terms of education, experience, and self-reported errors. Even in communication skills, foreign-trained nurses show comparative strengths on some dimensions.

A. Education

Foreign-born nurses and aides both have higher levels of education than do their native-born counterparts. The higher level of education among foreign-born aides may indicate some decredentialing of nurses.

Table B24: Years of Education, Nurses and Nurse Aides, 2000

| | Nurses | | Nurse Aides | |
|----------------------|--------------|-------------|--------------|-------------|
| | Foreign-Born | Native-Born | Foreign-Born | Native-Born |
| < High school | 1% | 1% | 21% | 20% |
| High school | 14% | 13% | 42% | 49% |
| 1–3 years of college | 43% | 64% | 27% | 28% |
| 4+ years of college | 42% | 22% | 11% | 3% |

Source: U.S. Census data, AARP PPI analysis

Although the sample sizes are small, the data in Table B25 indicate that countries vary in their educational requirements for nurses. Nurses from less developed countries such as the Philippines, China, and India are much more likely to have baccalaureate degrees than are nurses from more developed countries such as Germany, Canada, or the UK.

Table B25: Basic Education for Registered Nurses by Country of Origin

| | High School Diploma | Two-Year Degree | Four-Year Degree | Other (Midwifery) |
|------------------------------|---------------------|-----------------|------------------|-------------------|
| Canada (N=120) | 70.0% | 12.5% | 17.5% | -- |
| China (N=12) | 16.7% | 25.0% | 58.3% | -- |
| Germany (N=8) | 75.0% | 12.5% | 12.5% | -- |
| India (N=38) | 42.1% | 5.3% | 50.0% | 2.6% |
| Iran (N=7) | 42.9% | -- | 42.9% | 14.3% |
| Nigeria (N=26) | 53.8% | 15.4% | 30.8% | -- |
| Philippines (N=77) | 6.5% | -- | 93.5% | -- |
| Former USSR (N=22) | 40.9% | 36.4% | 9.1% | 13.6% |
| United Kingdom (N=26) | 61.5% | 15.4% | 19.2% | 3.8% |
| Other (N=109) | 41.3% | 18.3% | 37.6% | 2.8% |

Source: CGFNS (2002)

B. English Language Proficiency

Language proficiency is one very important measure of quality, since so much of long-term care depends on interpersonal communication and service. According to the self-assessments used in the census, relatively few foreign-born nurses indicated that they did not speak English or did not speak it well. This finding is not surprising since foreign nurse candidates must demonstrate English proficiency as part of the licensing process. However, nearly 12 percent of foreign-born nurse aides in long-term care settings said that they could not speak English or that they could not speak it well.

Table B26: English Proficiency, Nurses and Aides in LTC Settings, 2000

| | Nurses | | Nurse Aides | |
|------------------------------|--------------|-------------|--------------|-------------|
| Speaks English | Foreign-Born | Native-Born | Foreign-Born | Native-Born |
| Yes, only English | 32% | 96% | 32% | 94% |
| Yes, speaks very well | 47% | 4% | 31% | 5% |
| Yes, speaks well | 18% | 0.4% | 25% | 0.8% |
| Yes, but not well | 2% | 0.2% | 10% | 0.4% |
| Doesn't speak English | 0.4% | < 0.1% | 2% | < 0.1% |

Source: U.S. Census data, AARP PPI Analysis

Independent ratings of English proficiency conducted by the Council of Graduates of Foreign Nursing Schools indicate higher levels of language difficulties than do census data. Part of the difference may be due to independent rather than self-evaluation. But part is also undoubtedly due to the fact that the CGFNS survey included only recently licensed nurses, while the census data include all foreign-born nurses, nearly two-thirds of whom have been in the country for more than 10 years. The higher levels of problems among candidates who had not yet passed the licensing examination indicate that language proficiency is one reason that failure rates are higher for foreign nurse candidates.

Table B27: Interviewer Rating of English Skills of Graduates of Foreign Nursing Schools, Who Are Candidates for RN License

| English-Language Skill | Licensed | Unlicensed* |
|---------------------------|----------|-------------|
| Like a native | 45% | ~12% |
| Speaks & understands well | 38% | ~52% |
| Some problems | 15% | ~27% |
| Significant difficulty | 2% | ~9% |

* Unlicensed usually indicates that the candidate has not yet passed U.S. credentialing tests.

Source: CGFNS (2002)

A survey by the National Council of State Boards of Nursing expanded the range of communication questions. While foreign-trained RNs and LPNs both indicated greater difficulty understanding English-speaking clients and staff, they expressed fewer problems in understanding non-English-speaking clients and in understanding physician orders—perhaps because most foreign-trained nurses have more nursing experience than do newly licensed U.S.-trained nurses. Overall, foreign-trained nurses were far more likely than U.S.-trained nurses to say that they have no problems with communication.

Table B28: Communication Issues among Foreign- and U.S.-Trained Registered and Practical Nurses

| | Registered Nurses | | Practical Nurses | |
|---|-------------------|--------------|------------------|--------------|
| | Foreign-Trained | U.S.-Trained | Foreign-Trained | U.S.-Trained |
| English is second language | 73.5% | 10.2% | 80.9% | 8.4% |
| No problems with communication | 61.5%* | 30.6%* | 68.1% | 45.6%* |
| Problems understanding English-speaking clients & staff | 12.1%* | 2.0% | 9.2% | 2.1% |
| Problems understanding non-English-speaking clients & staff | 27.2% | 51.6%* | 28.9% | 29.7% |
| Problems reading or understanding physician orders | 12.1% | 53.2%* | 9.5% | 41.3%* |
| Other | 6.2% | 3.2% | 2.2% | 1.8% |

* Significantly related to self-reported errors. Source: Smith and Crawford, 2004

C. Work Experience

Foreign-trained RNs and LPNs generally have more experience than do recently licensed nurses who received their training in the United States. On average, they have worked in those positions for seven and a half years, according to the NCSBN (Smith and Crawford, 2004) survey. Data from the CGFNS similarly show that most foreign-trained RNs and LPNs have a number of years of work experience. LPNs may have somewhat more experience than RNs.

Table B29: Years of Work Experience among Foreign Nurse Graduates before Coming to the United States

| | Licensed RNs | Licensed LPNs |
|---------------------------|---------------------|----------------------|
| No Work Experience | 11.5% | 9.0% |
| 1–5 years | 30.8% | 41.3% |
| 6–10 years | 17.6% | 22.3% |
| 11–15 years | 8.2% | 13.5% |
| 16–20 years | 5.4% | 7.2% |
| 21–30 years | 2.6% | 4.6% |
| >30 years | -- | 0.7% |
| Unknown | 23.9% | 0.9% |

Sources: CGFNS (2002, 2005)

D. Errors

Foreign-educated nurses are less likely to report being involved in errors, especially those related to medication management. U.S.-educated nurses are more likely to point to inadequate communication, lack of support, and lack of supplies as institutional causes of errors. Foreign-educated nurses are more likely to cite inadequate orientation.

Table B30: Involvement in Errors Reported by Newly Licensed Nurses

| | RNs | | LPNs | |
|---------------------------------------|---------------------------|------------------------------|---------------------------|------------------------------|
| | U.S.- Educated | Foreign- Educated | U.S.- Educated | Foreign- Educated |
| Involved in errors | 53% | 30% | 40% | 21% |
| Types of Errors | | | | |
| Medication | 78.3% | 56.7% | 78.7% | 45.1% |
| Delays in care | 37.1% | 43.3% | 33.0% | 31.4% |
| Falls | 38.1% | 44.2% | 52.1% | 52.9% |
| Elopement | 12.6% | 6.7% | 11.7% | 2.0% |
| Impaired professional | 1.7% | 1.9% | 2.1% | 0.0% |
| Avoidable death | 0.0% | 2.9% | 1.1% | 0.0% |
| Workplace Causes of Errors | | | | |
| Inadequate staffing | 67.8% | 66.9% | 62.9% | 73.5% |
| Inadequate communication | 46.8% | 39.1% | 47.0% | 42.9% |
| Inadequate orientation | 27.1% | 32.1% | 27.8% | 45.0% |
| Lack of support | 21.2% | 8.6% | 9.6% | 7.9% |
| Long work hours | 19.5% | 14.9% | 23.9% | 20.9% |
| Lack of supplies | 18.5% | 11.3% | 20.9% | 16.9% |
| Policies & procedures | 18.1% | 17.9% | 18.7% | 16.9% |
| Other | 15.0% | 12.3% | 11.3% | 7.4% |

Source: Smith and Crawford, 2004

V. Income

Critics sometimes argue that foreign long-term care workers depress wages. However, census data indicate that foreign-born nurses and aides both earn substantially higher wages (based on the assumption of a 40-hour week) than do their native-born counterparts. One explanation for the difference may be the fact the disproportionate numbers of foreign-born nurses and aides work in metropolitan areas where wages are generally higher.

Table B31: Income, Nurses and Nurse Aides in LTC Settings, 2000

| | Nurses | | Nurse Aides | |
|----------------------|--------------|-------------|--------------|-------------|
| | Foreign-Born | Native-Born | Foreign-Born | Native-Born |
| Mean income | \$36,200 | \$29,300 | \$19,700 | \$15,500 |
| Median income | \$34,000 | \$28,000 | \$17,000 | \$13,800 |

Source: U.S. Census data, AARP PPI analysis

The poverty status of foreign- and U.S.-born nurses differs little. But native-born aides were much more likely than were foreign-born aides to have incomes below the poverty threshold.

Table B32: Poverty Status among Nurses and Nurse Aides in LTC Settings, by Nativity, 2000

| | Nurses | | Nurse Aides | |
|--------------------------|--------------|-------------|--------------|-------------|
| | Foreign-Born | Native-Born | Foreign-Born | Native-Born |
| Below poverty | 3% | 4% | 11% | 17% |
| 100–200% poverty | 9% | 10% | 25% | 28% |
| >Twice poverty | 88% | 86% | 64% | 54% |

Source: U.S. Census data, AARP PPI analysis